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**The Analysis of Therapeutic Improvisatory Music with People
Living with the Virus HIV and AIDS.**

**Submitted by Colin Andrew Lee
as a thesis for the degree of Doctor of Philosophy.**

The City University

Department of Music

June 1992

02027 3149

This Project is dedicated to :

Eddie and Charles, and to the memory of

Francis Towersey and Celia Mulville.

**"Here is no final grieving, but an abiding
hope. The moving waters renew the earth.
It is Spring."**

(Tippett : A Child of Our Time.)

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Colin Andrew Lee.

Abstract.

This project is concerned with the musical and therapeutic processes involved in therapeutic improvisation.(1) Previous studies in music therapy have, in the main, focussed their attention on avenues of outcome, attempting to validate through strict psychological designs and statistical data. This thesis argues that the musical and therapeutic processes are integral yet independent aspects of the overall concept of therapeutic improvisation and the efficacy contained therein. In terms of valid enquiry it is proposed that the unity and division of both musical and therapeutic avenues will afford music therapists a greater clue to the understanding of the music therapy process itself.

In terms of analytical and methodological framework, this project attempts to discover a formula for viewing the therapeutic improvisation at both macro and micro levels. Three clients, living with the virus HIV and AIDS were chosen and worked with collaboratively throughout the whole of the data collection. The investigations were initiated through a four-stage analytical format ; from the complete therapeutic framework through to the indepth evaluations of two small sections of one complete improvisation. The four stages were subsequently evaluated in drawing possible connections between the macro and micro levels. Further to this data, the client and three outside validators added information with regard to the single improvisation, in validating the questions raised. The analysis and subsequent results highlight the merits and problems of such an analytical procedure.

The conclusion and results of this thesis would seem to suggest that further process-orientated research in music therapy needs to be undertaken to complement and contrast the issues of outcome research.

1. For the purposes of this project the term Therapeutic Improvisation has been chosen to identify the improvisational aspects of music therapy.

Introduction.

Process research in music therapy is a relatively recent phenomenon in Great Britain. The bulk of research undertaken to date, has focused in the main on avenues of outcome. Suggested reasons for this can be divided into two main areas ; a) the need for answerability and validation, and b) the nature of the client group being researched (Learning Difficulties / Mental Illness). The recent move towards working with clients that are verbally articulate, and the refining of clinical practice, has meant that music therapy should now address the processes that are contained within its own paradigm. This introduction will consider an appropriate definition of music therapy for people living with HIV and AIDS, provide a critical review of the music process research already undertaken, and give a brief summary of the contents of the whole project.

Defining Music Therapy.

The difficulties in attempting to articulate succinctly, a practice that affiliates itself with two opposing disciplines, art and science, and which contains a broad differential in professional competency, means that any one definition of music therapy must be contained within strict criteria appropriate for that particular approach and training. Bruscia (1989), compares and categorises forty-two differing definitions of music therapy in an attempt to find common and differing elements of intention. His study highlights both the positive diversity of music therapy definitions and the possible problems facing the profession in presenting a unified approach.

One of the main discrepancies with all present definitions, is the use of language and its applicability for people who are neither mentally ill or who have a learning difficulty. Whilst the Association of Professional Music Therapists (APMT) in Great Britain published definition in 1982 contains the most accurate representation of the music therapy process developed during this project, there are certain phrases which need to be clarified and altered if this declaration is to be applicable for people living with HIV and AIDS. Whilst the original definition has been subject to minor alterations, and has been used in varying formats since that time, (Standing Committee of Arts Therapies Professions.) (1990) its phraseology is not applicable to this work. The following has been adapted from the original APMT definition :

"Music Therapy, is the use of predominantly improvised music, to fulfil therapeutic aims for, and in conjunction with, the client. It provides a framework for the building of a mutual relationship through which the music therapist will communicate with the client, exploring avenues of musical expression, that will reach, support, and develop the client's potential. The growing relationship enables change to occur, both in the state of the client, and in the form the therapy takes. By using music creatively, the therapist seeks to enable an interaction - a shared musical experience - leading to the pursuit of therapeutic goals. These goals are determined by the client's and therapist's understanding of the client's personal needs."

Process Research in Music Therapy.

Schmidt (1984), was the first music therapist to consider an analytical investigation in considering the musical processes contained within music therapy. The main aim of her study was to examine a Nordoff-Robbins play song, "Something is going to happen" in terms of a Schenkerian analytical model. This initial step into the investigation of musical processes, whilst limited to an analysis of the structure of the music alone, did raise some interesting and contentious points :

"Though careful theoretical analysis of musical structure may be overlooked by music therapists in their concern with client's behavioural responses, perhaps some aspect of the very structure of the music being used is serving to facilitate or inhibit client's behavioural responses. If research shows that such factors do exist and if one could delineate those factors, the use of music in therapy could become a much more exact art merging with science."

The need to focus on questions of process, alongside those of outcome, was initially identified in Great Britain, by Steele and Dunachie (1986), who conducted an investigation into a small section of music therapy improvisation, attempting to focus on the possible connection between musical content and therapeutic outcome. The accuracy of their results however, was hampered by problems of aural notation and qualitative interpretation of their chosen client (a child with learning difficulties). Ruud (1990), focuses on similar problems of interpretation, through the musical study of the opening measures of an improvisation with a child with behavioural problems :

"The question is how we might go on in the process of proceeding from the structure of music to possible phantasies, images or associations by the client and the therapist. The procedure illustrates how every step of description includes a possible interpretation. We may thus never be sure that the description of the client's music which therapists suggest is the same as given by the client himself."

These studies highlight the problems of validating musical content and its possible results, in understanding the music therapy process, when the client is unable to provide personal feedback.

Bunt (1985), and Odell (1989) in the concluding stages of their research projects identified the need for process orientated research :

"There is a fundamental need to focus more on the musical material....., We need to look more closely at the musical strategies which lead to the various therapeutic outcomes." Bunt.(1988)

"More research is necessary in order to obtain more information about how music therapy works, and in particular how methods vary, depending upon the client's difficulties, and needs. What exactly is taking place during the music therapy process which contributes towards change. ?" Odell. (1989)

These statements arose from in depth studies of music therapy outcome. Bunt and Hoskyns (1987) suggest that a synthesis of the two styles of research could provide : "a more comprehensive and satisfying analysis of the intervention." Bunt (1990), reiterates this belief :

"Do I detect a slight doubt that such work (outcome) is of the past and that we are now moving, at least in music therapy research, into the more interesting process-type questions ? Rather than continuing to play victim to this implied polarity would it not be a challenge to bring process and outcome together ?"

Certainly it would appear incongruous to isolate one or other approach. Process research is inextricably linked to avenues of outcome in terms of viewing the music therapy process, and in the possible link between hypothetical questioning, and results. To focus on either process or outcome as an unrelated research procedure would ally the essence of balanced questioning. These assumptions would appear to validate the perspective that there is now strong evidence to support the view that music therapy needs to develop new methods of research, in order to address the unique qualities of its theory, and practice. (Bruscia 1989)

My own initial investigations of process orientated research, focused on music analytic approaches via two studies of part-improvisations (tonal and post-tonal) from the same client. (Lee 1989, 1990) The problems encountered were as follows :

- 1) Aspects of subjectivity in analysing the improvisation of a non-verbal client. (see Steele and Dunachie 1986).
- 2) Problems in adapting theoretical models of music analysis to music therapy improvisation.

3) Assumptions with regard to formal musical complexities and their relevance to the music therapy process.

The result of these investigations provided strict criteria for the analyses contained within this project :

1) that music analytic procedures should be freely adapted to answer the questions of music therapy improvisation, and should not be considered in the strict boundaries of their derivation.

2) that verbally articulate clients are essential if elements of subjectivity are to be decreased.

3) that the structural intricacies of the improvisation should only be considered as significant, if they are directly corroborated as being related to the music therapy process.

4) that in order to produce significant results, outside validators should be incorporated to eliminate variables of analytic procedure.

Recently completed and on-going process orientated research projects in Great Britain (Van Colle 1992, Dunachie 1992, Pavlicevic 1991, Aldridge 1989, 1991.) would suggest that the issues and problems discussed in this introduction are now being tackled within various methodological frameworks.

Hypotheses of the Project.

1. That in therapeutic improvisation for people living with the virus HIV and AIDS, it is possible to perceive a direct link between musical representation and therapeutic development.

note. This is facilitated by : a) the therapist's own experience in music therapy and his/her understanding of the client's needs and b) the client's stage within the therapeutic process.

2. That the musical components of therapeutic improvisation are as important as the therapeutic evaluations in highlighting and evaluating the efficacy of music therapy for people living with the virus HIV and AIDS.

3. That specific musical themes and/or motifs are employed (consciously or subconsciously) as a generative basis for the therapeutic improvisation as a whole.

4. That the musical preference and culture of both client and therapist have a direct effect upon the musical components incorporated within the therapeutic improvisation. This may consequently affect the therapeutic outcome.

Guide to the Following Chapters.

Volume One. Part One.

Chapter one will review the current literature on music therapy in hospice/palliative care. It will suggest the need for a specific therapeutic model when working with people living with HIV and AIDS, as distinct from people with other terminal illnesses. A statement of my own personal experiences will provide a balanced, contextual evaluation from the therapist's perspective.

Chapter two will concern itself with a review of the literature on improvisation, its psychological background, relevant theories, and analysis. Models of music therapy improvisation will be discussed culminating in a proposed definition of improvisation in music therapy relevant for the following chapters.

Chapter three describes the experimental procedure and methodology of part two.

Part Two.

Chapters four to six contain the main bulk of the thesis : three investigations of a single piano improvisation with a client, in individual music therapy, living with HIV and AIDS. Each analysis is divided into four stages : 1) An idiosyncratic description - an overall account of the therapeutic process, 2) An integral investigation - viewing the whole improvisation, 3) Two constituent analyses - selected sections of the improvisation for in depth analysis, and

4) Evaluation and synthesis. The data has been collected from two independent sources ; 1) The music - accurate transcriptions via a Yamaha MIDI - Grand Piano, 2) Aural validation - the client, a musician, a music therapist, and a counsellor. There is no strict analytical structure implied for the analysis of each improvisation, rather the methodology is incorporated as guidelines for each investigation. Variables occur both in the musical ability of each client and the player positioning of each improvisation :

Client One - Eddie - no musical expertise. Piano four-hands, client - treble, therapist-bass.

Client Two - Charles - musically moderate standard. Piano four-hands, client- bass, therapist-treble.

Client Three - Francis - musically high standard. Solo piano - client.

Chapter seven, the review of findings, is concerned with comparing and contrasting the stage four investigations of chapters four to six, in formulating an overall evaluation and synthesis of therapeutic improvisation for people living with HIV and AIDS. This chapter will subsequently discuss the implications of these results, and their significance for future music therapy research.

Volume Two.

Volume two contains the complete improvisations in their transcribed and audio format, plus three previous publications.

Part One.

Chapter One.

Music Therapy and Terminal Illness.

1.1. Introduction.

This chapter will begin by considering the most recent medical and sociopolitical information available with regard to HIV and AIDS. The psychoneuroimmunological consequences of the individuals' psychological responses will be discussed and the possible effects of therapeutic intervention. A survey of music therapy in hospice/palliative care will provide the basis for a proposed therapeutic procedure working with people living with HIV and AIDS. In conclusion this chapter will balance the therapeutic alliance by considering the issues faced by both client and therapist.

1.2. A Brief Medical and Sociopolitical Survey of HIV and AIDS.

The condition now commonly referred to as AIDS was first reported in the USA in 1981. (Medical and scientific group, Terrence Higgins Trust 1991) 159 citations were confirmed during June to November of that year. The first documentation of AIDS in the UK was received in London in December 1981. It appears that there were people living with the virus before that time, but that the condition was rare.

AIDS is now prevalent in most countries, and occurs mostly in large towns. The recorded number of people with AIDS in developing

countries is less clear with no formal figures having been announced until 1983. Consequently accurate figures worldwide are unclear ; the World Health Organisation has received numbers in excess of 305,000, though it is estimated that the figure is more likely to be nearer 800,000, with approximately between nine to ten million people infected with HIV.

The estimation of the most recent figures in the United Kingdom falls into two categories : a) those people with HIV, and b) those people with AIDS. (see Figures One and Two)

There are problems in accurately presenting the current information available. This is due to the eruption of definitions and re-definitions, of terminologies and clinical practice , articles, research projects and journals. Consequently this section can only hope to give a general overview with regards to the current trends in HIV and AIDS. It will present the basic medical and social issues, concluding with a discussion on the changing client groups and the effects this will have for the future care of people with HIV and AIDS.

1.2.1. Definition – Immunology – Virology – Drugs.

Definition.

The Terrence Higgins Trust has defined AIDS as the following :

"AIDS stands for Acquired Immune Deficiency Syndrome. "Acquired" refers to any condition which is not present at birth. "Immune Deficiency" means that the body's immune system, which fights off illnesses, is not working efficiently. AIDS is not a

G.62 (2)
TABLE 4 HIV-1 INFECTED PERSONS BY EXPOSURE CATEGORY AND DATE OF REPORT: UNITED KINGDOM TO 31ST DECEMBER 1991

(Numbers subject to revision in the light of further data received.)

How persons probably acquired the virus	Jan 90 Dec 90				Jan 91 Dec 91				Jan 92 Dec 91			
	Male	Female	NS*		Male	Female	NS		Male	Female	NS	
Sexual intercourse between men	1500	-	-		1374	-	-		9954	-	-	
between men and women	7	40	-		13	35	-		41	234	1	
"high risk" partner ¹	157	130	1		191	181	4		612	485	11	
other partner abroad ²	15	22	-		15	22	-		57	76	2	
other partner UK	23	27	-		50	35	-		148	154	-	
under investigation	166	46	1		145	61	-		1501	693	30	
Injecting drug use (IDU)	31	-	-		17	-	-		193	-	-	
IDU & sexual intercourse between men												
Blood factor (eg haemophilia)	57	-	-		4	-	-		1259	8		
Blood/tissue transfer (eg transfusion)	3	13	-		7	14	-		74	80	1	
abroad/UK												
Mother to child	17	17	-		12	9	-		51	55	1	
Other/undetermined	59	13	6		107	33	2		856	167	84	
Total	2035	308	8		1935	390	6		14746	1952	130	

1. Includes men and women who had sex with injecting drug users, or with those infected by contaminated blood and women who had sex with bisexual men.

2. Includes persons without other identified risks from, or who have lived in, countries where the major route of HIV 1 transmission is through sexual intercourse between men and women.

* NS - Sex not specified in report.

Figure One.

3.62 (1)
TABLE 1 AIDS CASES (KNOWN DEATHS) BY EXPOSURE CATEGORY AND DATE OF REPORT: UNITED KINGDOM TO 31 DECEMBER 1991
(Numbers subject to revision in the light of further data received.)

How persons probably acquired the virus	Jan 90 Dec 90		Jan 91 Dec 91		Jan 92 Dec 91	
	Male	Female	Male	Female	Male (Deaths)	Female (Deaths)
Sexual intercourse between men	941	-	965	-	4197 (2650)	-
between men and women "high risk" partner ¹ other partner abroad ² other partner UK	3 70 3	9 30 6	6 86 20	8 54 6	16 228 33 (8) (117) (15)	32 116 17 (21) (50) (7)
Injecting drug use (IDU) IDU & sexual intercourse between men	63 22	18 -	54 19	31 -	176 83 (98) (53)	69 - (43) -
Blood Blood factor (eg haemophilia) Blood tissue transfer (eg transfusion) abroad UK	60 2 2	1 10 6	62 1 1	1 4 4	286 14 16 (206) (11) (14)	4 28 18 (3) (18) (11)
Mother to child	6	7	5	10	18 (8)	31 (14)
Other/undetermined	12	1	29	4	61 (40)	8 (4)
Total	1184	88	1248	122	5128 (3220)	323 (171)

1. Includes men and women who had sex with injecting drug users, or with those infected by contaminated blood and women who had sex with bisexual men.

2. Includes persons without other identified risks from, or who have lived in, countries where the major route of HIV 1 transmission is through sexual intercourse between men and women.

Figure Two.

single disease: it is a "Syndrome" - or group - of specific infections and cancers, which occur because the body's immune system has been compromised. This "immune deficiency" is a late consequence of infection by a Human Immunodeficiency Virus (HIV)." (1991)

It was initially thought that it was not the virus itself that caused death but the opportunistic infections that take advantage of the suppressed immune system. (Winiarski 1991) Recent research has now contradicted this theory, and it is a commonly held belief that HIV related illnesses are caused both from the direct effects of the virus as well as opportunistic infections. Due to the recent discovery of the virus, research being undertaken with regard to the percentages of people acquiring AIDS through the HIV infection, are constantly being updated, with no clear evidence being available to support or contradict the connection between the two. It is usual for a person with the HIV infection to experience symptoms within the first three years, except for babies being infected prior to birth. This figure however depends on each individual, several cases having been reported of people living for eight years without recognisable symptoms. Recent evidence has suggested that : "within ten years, up to fifty percent of people with HIV infection will progress to AIDS, and a further twenty to thirty percent will have some HIV related illness, if no treatment against HIV is given" (CDSC 1989)

Immunology.

In order to understand fully how the HIV virus develops into immune deficiency, a brief investigation of the immune system specifically related to AIDS should be considered.

The immune system defends us against "foreign invaders" : bacteria, viruses, parasites, and mutant cells. It has two main subsections, the first produces B-cells evolved in bone marrow producing humoral immunity, and the second more appropriate to AIDS, is called cell-mediated immunity, creating T-cells in the lymph nodes. There are five categories of T-cells, some killer T-cells attack infections, others tumours. People with the HIV infection have a normal amount of killer cells but they are unable to attack tumour cells. (Rook et al., 1985) There are two types of T-cells in relation to AIDS, the T-helper T-4 cell, and the T-suppressor cell. The T and B cells are known as lymphocytes, which is the common expression for an individual cell of the immune system. Macrophages originate from monocytes leaving the blood stream, which digest foreign matter. The macrophages and circulating CD-4 cells become the first targets of the virus, though other specific cells of the "gastrointestinal tract, uterine cervical cells, and glial cells of the central nervous system (CNS) may also be targets" (Volberding and Cohen, 1990)

Virology.

HIV is associated with a sub-group of the retrovirus called lentiviruses. The retrovirus are sections of genetic material composed of two single strands of RNA (ribonucleic acid), protected in order to gain access to cells. The HIV protective element helps gain the ability to enter other cells. HIV is known to attack various cells via "unknown receptors" (Levy, 1990), although the CD-4 infection has been researched the most. The CD-4 counts, measured via the blood, appear to indicate the clearest state of a person's immune system. Normally a person's CD-4 level will rise above 500 counts in a cubic millimeter of blood, people with a critical HIV infection however being

as low as 50, 10, or no CD-4 cells.

The CD-4 cells are taken over slowly. The virus attaches itself to the cell ; once focussed the viral RNA employs a double strand of DNA (deoxyribonucleic acid) called a provirus. It is taken into the cell's genetic code, becoming active only when there is a threat of pathogen. At this point it finds new viral RNA, dividing the infected cell and creating new viral protein completely destroying the CD-4 cell.

This above explanation cannot be termed as authoritative, and serves to present the theories that have been achieved up to 1990. Recent research has already shown that the specialised receptor site, entering into the cells by the HIV virus, is not in itself enough to destroy the CD-4 cells. As work continually develops into defining the cause and effect of the break-up of the immune system, so new and differing theories will be discovered.

Drugs.

The term "drug-of-the-month phenomenon" is a trend that has appeared in recent years with the desperate bid to discover a vaccine that will both prevent people from becoming infected with the virus, and that will cure those already living with HIV and AIDS. There is not space within this project to explore all the psychological and immunological consequences this recent trend could potentially have on a person's health, albeit that this unfortunate development has added considerably to the difficulties already faced by those living with the virus.

The following list presents those drugs most commonly used to treat the HIV infection :

(a) ZIDOVUDINE (AZT, "Retrovir")

Zidovudine is a drug which blocks one of the enzymes which HIV requires for reproduction. It is now widely used in developed countries to treat people with AIDS or other serious HIV-related illness. Zidovudine given to people who have recovered from PCP (see 1.2.2.) or have a "wasting syndrome" with other features of Aids Related Complexes, (ARC) has resulted in a four- to six-fold reduction in expected mortality after nine months.

The main side-effects of zidovudine are related to toxicity to bone marrow (which makes blood cells), which may necessitate regular blood transfusions, reducing the dose or even stopping the drug.

People with less advanced HIV related illness may tolerate zidovudine better than people with AIDS, so treatment should be started earlier rather than later.

Research concluded in the USA in August 1989 suggested that some people who are infected with HIV, and are well, have a smaller chance of developing illnesses with at least one year's treatment with zidovudine.

(b) INTERFERONS.

These have been used in the treatment of Kaposi's Sarcoma, but have serious side-effects. However, a combination of zidovudine with interferon alpha may have increased beneficial effects in KS.

(c) SOLUBLE CD 4

CD 4 is a protein on the surface of some T lymphocytes (white blood cells), to which HIV binds. A soluble form of this protein could bind to the virus and prevent it from binding to human T cells. It has yet to be of proven value, but studies are currently in progress.

(d) PENTAMADINE.

This is a drug which can be used to treat PCP (see 1.2.2.) and will prevent its recurrence. It is currently being tested for use in an aerosolised form which delivers a lower total dose of the drug directly to the lungs, in order to reduce the risk of side effects.

(e) ACYCLOVIR (ZOVIRAX)

This is a drug which is active against herpes viruses. (see 1.2.2.) Herpes simplex and shingles can be fatal in people with AIDS. Acyclovir may be given on a long term basis to people with HIV who have had an attack of shingles, or frequent attacks of herpes simplex.

(f) DIDEOXYINOSINE (ddI), and DIDEOXYCYTIDINE (ddC)

These belong to the same class of drug as Zidovudine and act in a similar way against HIV. At present there is only limited evidence of the clinical benefit of these drugs for people with AIDS. There is more evidence that, like zidovudine, they have a positive effect on the T4 cells of the immune system. Neither ddI and ddC penetrate the nervous system to the extent zidovudine does. The side effects associated with ddI and ddC are different from those associated with zidovudine and are currently less well understood. The most

serious appear to be a painful burning sensation in the extremities, called peripheral neuropathy, which can occur with both ddi and ddC, and pancreatitis neuropathy, which affects around one in ten people taking ddi and has been fatal in a small minority of cases.

(Terrence Higgins Trust 1991)

1.2.2. Transmission - The Stages of the Virus - Diseases Common in AIDS.

Transmission.

The HIV virus is transmitted by acquiring an infected persons fluids into one's own body. The usual means of transference are :

- (i) Sexual contact - Through anal or vaginal intercourse.
- (ii) Blood - (a) Through the shared use of needles and syringes. (b) blood transfusions and products made from blood to treat haemophilia. note - this form of transmission did not occur after 1985.
- (iii) In the utero - From mother to baby.

The Stages of the Virus.

Positive HIV Testing. - The incubation period, or "window of nondetectability". (Winiarski 1991) This period lasts for as long as it takes for the person to acquire the antibodies. It could be as long as six months, though is normally not less than three to four

months. Through recent technology the virus can now be detected before this time, although it can still be considered questionable due to its tendency of false-negative results. (Cohen 1990) Once an HIV-antibody-positive result has been determined, about a quarter of people infected will experience some mild symptoms, (fever, headaches, rash, joint and muscle pains) after which there is a variable period where no physical symptoms are manifested. (HIV- positive but asymptomatic) This incubation period has increased considerably with a greater knowledge and understanding of the workings of the virus. (Bacchetti and Moss, 1989; Lifson et al., 1989) It has now been generally determined that AIDS develops within eight years. (Goedert et al. 1989)

Experiencing Symptoms. An AIDS diagnosis. - The Centers for Disease Control (1986) has classified stringent criteria before an AIDS diagnosis can be verified. If all these criteria are not met the person is told to be of "HIV- related symptomatic illness," until which time an AIDS diagnosis can be clearly ascertained.

Diseases Common in AIDS.

The following list comprises those conditions most commonly associated with HIV and AIDS :

- i) Pneumocystis carinii pneumonia. (PCP) - An infection of the lung.
- ii) Cryptosporidiosis. - A protozoal gut infection, often causing diarrhoea.
- iii) Cryptococcal meningitis. - A fungal infection of the brain.

- iv) Cerebral toxoplasmosis. - A protozoal infection causing brain abscesses.
- v) Herpes Viruses. - A virus which causes major problems in AIDS. Most seriously infected are the eyes, bowel, lungs and brain.
- vi) Kaposi's Sarcoma. (KS) - The only common type of cancer in AIDS. KS usually affects the skin.
- vii) Lymphoma. - A cancer of the lymph nodes.
- viii) AIDS dementia. - Aids dementia is more common in those who have had AIDS for a long time.

1.2.4. Sociopolitical Issues and Human Rights.

HIV and AIDS is a stigmatized illness. It is classed as a disease acquired through immoral means : sex, particularly anal, and through needles. The terms "sufferer" and "victim" are still in common usage, even though the generally accepted phrase promoted within all the AIDS organisations, is that of a person "living with AIDS" Persecution of people with HIV status continues and can be illustrated by the following personal statements :

**"I was treated appallingly by the local police....the next day I found that my confidential conversation (with the chief inspector) was all over the papers....I then had the press knocking at my door, hounding my neighbours, trying to take photographs of myself and my son. They even went to my son's school...I had to leave our home, and move."
(England, female)**

"Last week my wife was in a large London teaching hospital (giving birth) to twins....The hospital knew my antibody status. My wife was barrier nursed, given meals on paper plates, ignored often....At least five doctors came in while I was there and asked

moronic questions about how I felt living with HIV....A giant "INFECTION" was written above her name." (England. male)

(Taken from : Stories from the delegates to the fifth International Conference for people with HIV and AIDS, 1991)

Human rights of the individual living with HIV and AIDS means the right to "medical assistance and welfare, to enable people to receive adequate care, to prevent further illness and to enable people to stay productive members of society for as long as possible". (Bolle 1991) International organisations : The World Health Organisation, The Council of European Communities and the human rights group "Rights and Humanity", are now actively working alongside people living with HIV and AIDS to promote new policies and to see that they are carried out. In 1989 Paul Sieghart conducted an indepth investigation into AIDS and human rights. (Sieghart 1989), and in England there is now a declaration of the rights of people with HIV and AIDS.

1.2.5. Changing Client Groups. – The Future.

Until recently the group most at risk of acquiring the virus were homosexual men. Figures published during approximately the last three years would suggest that whilst the highest numbers still occur in homosexual and bisexual men, that the figures in other client groups are now rising. (see Figures One and Two) HIV and AIDS is now an issue that faces everyone (Lee 1991), and is not confined to any particular section of society.

There is no cure for AIDS, and the emergence of a vaccine to prevent the HIV infection, it is estimated, could take many years to develop. It

appears that the efforts to restore the immune system are more likely to be successful if an anti-viral therapy is used in conjunction with drugs like Zidovudine. (Terrence Higgins Trust 1991)

1.3. AIDS. Psychological Responses. Psychoneuroimmunology, and Therapeutic Intervention.

It has been proven that there is a definite correlation between stress and the progression of the HIV virus. (Solomon 1985) Also that ; "The perspective a patient has on his or her illness or infection can play a significant part in the development of his or her condition." (Miller 1987) The hypothesis of this section subsequently considers the possibility that; "If it is felt decisive that therapeutic intervention does affect and alter the standing of the person, then this must consequently influence the psychoneuroimmunological considerations for that individual." (Lee 1989)

1.3.1. Psychological Problems.

Depression, anxiety and social isolation are some of the commonest reactive complications of AIDS. (Thompson 1989) Acute emotional responses can manifest themselves soon after a positive diagnosis ; "The fact that it was all in the future made it no less real, and somehow more difficult to cope with than if it was happening now." (Grimshaw 1990) The social implications of AIDS and the possible repercussions can produce lack of self-esteem and isolation : "I wouldn't tell anyone.... I was very frightened that once the neighbours and my friends knew, they would have nothing to do with me." (Honigsbaum 1991)

Following diagnosis there can be further, often more intense, periods of extreme anxiety and depression. These causable emotional responses have been classified by Miller and Brown (1988) :

Shock :

- Over diagnosis and possible death
- Over loss of hopes for good news

Fear and Anxiety :

- Of uncertain prognosis and course of illness
- Of disfigurement and treatment
- Of effects of medication and treatment
- Of isolation and abandonment and social/sexual rejection
- Of infecting others and being infected by them
- Of loved-one's inability to cope with their possible illness
- Of loss of cognitive, physical, social and work abilities

Depression :

- Over "inevitability" of health decline
- Over absence of a cure
- Over the virus controlling future life
- Over limits imposed by ill-health and possible social, occupational, emotional and sexual rejection
- From self-blame and recrimination for being vulnerable to infection in the first place

Anger and Frustration :

- Over inability to overcome the virus
- Over new and involuntary health/lifestyle restrictions
- At being "caught-out" and the uncertainty of the future

Guilt :

- Over past "misdemeanours" resulting in "punishment"
- Over possibly having spread infection to others
- Over being homosexual or a drug user

Hypochondriasis and obsessive disorders :

- Relentless searching for new physical diagnostic evidence
- Faddism over health and diets
- Preoccupations with death and decline, and avoidance of new infections

Acute psychological problems are experienced by the loved-ones and carers also. (Miller, 1987. Jacoby-Klein and Fletcher 1986)

1.3.2. Dementia and Psychiatric Needs.

Psychiatric disorders such as dementia, may occur through either direct damage to the central nervous system by the virus, or by opportunistic infections of the brain. The former, known as "AIDS dementia complex", is the most common cause, and in some cases can be the sole manifestation of AIDS. Dementia primarily manifests itself as a combination of cognitive, motor and behavioural disturbances, and may be initially thought to be the features of a depressive disorder. Over a period of normally months, it "progresses remorselessly in the majority to a picture of profound global dementia associated with mutism, incontinence and eventual coma, death usually resulting from intercurrent infection." (Fenton 1987)

AZT may offer help, but will not remove the virus from the brain. (AVERT 1989), and it is estimated that one-third of all people living with AIDS will develop some clinical signs of dementia. (Thompson 1989) Recent speculation has proposed that AIDS-related dementia may appear as a long-term, non-fatal symptom not unlike Alzheimer's disease.

The growth of dementia amongst people living with the virus, will have direct repercussions on psychiatric services; "There is good reason to suppose that by the mid-1990s psychiatry will have become a "front-line" speciality in the management of AIDS." (Fenton 1987) Because AIDS is a disease that, in the main, is associated with behaviour, its professional remit must subsequently fall within the purview of psychiatry. The mental health profession has thus an obligation to intervene. (Dilley 1988)

1.3.3. Psychoneuroimmunology.

Psychoneuroimmunology is involved with the relationship between the immune system and the central nervous system. (Booth 1990) Whilst the immune system is capable of functioning separately, there are complex relationships between the immune system and the nervous system with ; "enormous potential for exchange of information between the two". (Ansdell 1990) The immune system can be affected and influenced by psychological correlates, which subsequently may effect the psychological processes themselves. (Melnechuk 1985) Several hypotheses have been suggested for the possible relationship between the immune and central nervous system, one theory proposing that personal coping strategies and inherent personality may affect the susceptibility of the immune system. (Solomon 1985) The hypothesis that the psychological issues faced by people living with HIV and AIDS (see 1.3.1.) directly influence both the immune and nervous system (Coates et al 1984), thus directly affecting health considerations, is reflected throughout this project.

1.3.4. Immuno Suppressive and Supportive Behaviour.

"Immune vulnerability" (Taylor, Spence 1989) is concerned with the result of psycho-social conditioning and its possible effects for the individual's coping strategies. This is a response to a conditional situation developed through fear. Spence categorises some of the elements in terms of immuno-suppressive and immuno-supportive "behaviour":

Immuno-suppressive

Poor diet/environment
Isolation
Addictions (psycho/physical)
Lack of self-esteem
"emotional dishonesty"
Denial of emotions
Passivity
Lack of (meaning, purpose)
Fear

Immuno-supportive

Good diet/environment
Social/emotional support

Self-acceptance
"emotional honesty"
Self-expressiveness
Creativity
Value
Sense of control

It is suggested through this interpretation that the individual's responses and behaviour – social, psychological, coping and biochemical – and their effects on the relationship between the immune and nervous system can be viewed as "a "habituated set" of reaction to the perceived "meaning" of a situation." (Ansde11990)

1.3.5. The Effects of Therapeutic Intervention.

The potential for incorporating therapeutic, alongside medical and drug intervention, has long been recognised as potentially crucial in treating a person living with HIV and AIDS. (Crimp 1988, Miller at al1 1987, Gilman 1988, Dilley 1988, Colon 1988, Fenton 1987.) Despite this identification there appears to be no strict "outcome study" that has considered therapeutic intervention and its possible effects on the immune system and health of a person living with HIV and AIDS. The available data considers qualitative descriptions only. Therapeutic techniques can be broadly sub-divided into three categories i) Psychotherapy, ii) Complementary/Holistic therapies, and iii) Art and music therapy.

i) Psychotherapy - It is suggested that the boundaries and therapeutic contract, when working with people living with HIV and AIDS, should be freely adapted to meet the special needs of this client group. (Winarski 1991, Bosnak 1989) This has subsequently required a complete re-evaluation of the theories and practices usually associated with psychotherapy. The question that has been raised is, how different is HIV-related psychotherapy from other psychotherapies ?. Winarski (1991) proposes the following avenues of psychotherapeutic goals and themes, in order to distinguish and differentiate HIV-related psychotherapy :

Therapeutic Goals.

Coming to terms.

Connection and reconnection.

Planning for the future.

Psychotherapy Themes.

Why me ?

Denial.

Shame and guilt.

Abandonment.

Betrayal.

Loss of control and dependency.

Fear of dying.

Loss of the future.

A life of unknowing

Living fully.

Family issues.

Financial concerns.

Envy of the healthy.

ii) Complementary/Holistic therapies - the most commonly used complementary/holistic therapies used by people with HIV and AIDS, have been termed for the purposes of this section as "passive intervention" ; that is, a therapeutic form "administered to", rather

than “actively experienced with” the client as in the sort of creative intervention described in this thesis.

The following complementary therapies are those available at London Lighthouse (1991), a centre for people facing the challenge of AIDS. Brief explanations of the aims and possible benefits are described :

Hypnotherapy – a deep state of relaxation, achieving a sense of calm, clearing the mind, and relieving anxiety.

Relaxation – Yoga breathing, focusing and gentle exercise, followed by deep relaxation using hypnotherapy techniques, and music.

Reflexology – a gentle form of massage working on pressure points on the foot to release tension, restoring lost energy and vitality.

Therapeutic massage – relaxation and recuperation by stimulating the nervous system ; improving the circulatory and lymphatic flow and gently mobilizing the joints. Massage can be used in tandem with other medical and complementary therapies to harness an improved state of health.

Acupuncture – the restoration of the natural balance of energy within the body. Needles are inserted into specific points, unblocking energy and relieving pain and discomfort.

Homeopathy – a powerful yet gentle therapy, which uses the principle “like cures like”, in which a substance that cause symptoms in a healthy person can be used to treat those symptoms when they appear as part of a natural disease. Homeopathy treats the whole person - physically, mentally and emotionally - increasing energy, vitality and sense of well-being.

A survey conducted in 1989 (Hand), with hospitalized patients, reported that eighteen out of the fifty were using one or more alternative therapies (acupuncture, imagery, therapeutic massage, megavitamins, acupressure, unapproved medications and high cereal diet). All the patients stated that they found alternative therapies to be of value but did not regard them as curative.

iii) Art and music therapy - art and music therapy constitute a relatively small role in the field of complementary therapies and AIDS. In Europe the work available is confined to music therapy, documented in Germany (Aldridge and Neugebauer 1990), Holland (Bos 1989) and England (Lee 1989-1992). In America an equally small number of publications are present. (David and Sageman 1987, Maranto 1988, Bruscia1991)

1.4. Music Therapy. in the Palliative/Hospice Care Setting. **Problems of Practice and Definition.**

The growth of music (Beck 1991, Caudrey 1987, Biley, McKenna 1992, Attig 1986, Papadatou, Papadatos 1991, Levine 1982, Cook 1986, Walter 1983, Brown 1992, Ellis, Dick 1992, Zimmerman 1989, Frampton 1986, Jacob 1986, Bailey 1984, 1983.), and music therapy (Gilbert 1977, Fagen 1982, Kerkvliet 1990.) in the palliative/hospice care setting has been a tentative and somewhat bewildering process. In Great Britain the hospice movement generally has shown a distinct lack of interest in music therapy, there being only one therapist employed at the present time by a hospice. Internationally the main concentration of music therapists working within this area has developed in Australia, Canada and America.

In the Hospice care setting palliative treatment is described as the following:

"the reduction or abatement of pain and other troubling symptoms by appropriate coordination of all elements of care needed to achieve relief from distress. This main term can be considered synonymous with "Hospice Care". (Ajemian. 1980)

Terminal care during the last twenty-five years has focussed on caring for people with cancer, (Seale 1991) although recent trends suggest that "many of the symptoms to be treated and much of the general management will be relevant to other situations." (Saunders and Baines 1983) One of the more recent causes of terminal illness that will require the services of the Hospice movement in the future is HIV and AIDS. The following critique of music therapy is focussed on the client living with cancer, who is in the later stages of his/her illness.

The beginnings of documented work in terminal care was spearheaded by Susan Munroe (1978). Her initial predictions for the possible use of music therapy with the dying, fell into four main areas; physical, psychological, social, and spiritual. The therapeutic procedures adopted from these categories, were developed mainly through the use of pre-recorded music. In a later publication (Munroe 1984) a more detailed documentation of the work is presented, the reader however, being left to consider and determine various approaches from the case studies provided.

In 1989 the first symposium for music therapists working in palliative care was held at Calvary Hospital, New York. (Ed Martin 1989) During the conference a group of music therapists met in order to collate and compare differing methods and techniques of practice. What transpired was a list of therapeutic interventions which ranged from the use of basic improvisational techniques, through to using nature/environmental sounds, and the combination of music and massage.

Clarification of practice and definition, when using the term music therapy to cover such a broad spectrum of approaches, is fraught with complications. Whilst it is not the intention of this chapter to suggest that music therapists should re-define their terminologies of practice, what it does propose is that if music therapy is to become established within this field, certain standard criteria of musical intervention and therapeutic outcome need to be established. Research would seem to be the appropriate forum from which to address these issues, though this in itself is limited (Forinash 1990, Munro 1988). In the following sub-headings I have chosen three of the most commonly used music therapy techniques : pre-composed, taped, and improvised music, in order to assimilate commonalities of work.

1.4.1. Pre-Composed Music.

The use of pre-composed music has been identified as an important tool in working with people with a terminal illness (Martin 1989, 1991, Whittall 1991, Beggs 1991, Ellis, Dick 1992.). It is stated that the benefits of this approach are that the client can decide upon music that reflects his/her current feelings. This provides a vehicle through which the client can express issues often too difficult to articulate

verbally.

Beggs (1991) describes the importance of "life review" techniques, directed through the study of pre-composed music with an amateur violinist in palliative care. "Life review" is a treatment method whereby music and words are used to explore the client's significant life experiences. In this case it was achieved through singing, playing, and listening to music that held special relevance during the client's life, prompting associations and memories as a basis for therapeutic evaluation. The intervention enabled the client to re-kindle important aspects of his creative life, thus promoting self-motivation and worth. During the later stages of his illness the music therapy relationship provided him with the ability to face his ensuing death, affording the opportunity of self-expression and dignity. Beggs concludes that the "life review" technique, when used in conjunction with pre-composed music, provides an effective open relationship between client and therapist. This provides the space for verbal and non-verbal exploration of the client's life, thus placing the latter's existence into a clearer perspective.

Song choice (Bailey 1984) is a simple technique, whereby the client requests a song which is subsequently played by the therapist. The client is then free either to listen or participate in the activity. Some of the benefits of this approach are as follows :

- 1) Direct and symbolic expression through lyrics.
- 2) The stimulation of memories.
- 3) As an avenue of sharing, between client and family.
- 4) Expression being contained within a set structure e.g. lyrics, rhythm, melody and harmony.

- 5) The song as an intermediary object of expression, when topics are too painful or frightening.
- 6) Elements of choice and control.
- 7) The alleviation of isolation through the shared musical experience.

Whittall (1991) discusses the importance of recording the songs sung during music therapy, enabling the client to have the facility to access the experience outside the session. Through her study of a client with terminal cancer, she concludes that the efficacy of music therapy developed both from the client's choice of songs, and the availability to listen back to the experience gained the client greater personal insight. Whittall suggests that this therapeutic approach also had far-reaching consequences for her loved ones. During the bereavement process, it provided her family and friends with the opportunity to use the tapes as a "transitional object", serving to provide them with a real presence of her personality.

The limitations of this model should also be addressed. It could be argued that the use of pre-composed music will act as a block in accessing other therapeutic avenues of equal importance. Through my own experience, the value of pre-composed music on one level enables the client to choose, and to share musically with the therapist. On another level, however, it can act as an intermediary object, whereby the client is able to side-track difficult issues that could potentially have far reaching consequences for the his/her development.

1.4.2. Pre-Recorded Music.

Pre-recorded music played a major role in therapeutic intervention during the formative stages of music therapy in palliative care. Munroe (1984) states that the advantages of this approach is the availability of taped music for the client day or night and, via the use of head phones, the potential complete privacy. She also states that taped music ensures the client the opportunity to be in control when other levels in the client's life may be diminishing. In describing her methodological approach (1978), she places great importance on the provision of a library of taped music that will match the needs of all clients' tastes, and ethnic backgrounds.

The benefits of pre-recorded music can be established at various different levels. In one case-study, Munroe describes how a client became too ill to continue playing the piano and how the use of records enabled the therapeutic relationship to continue, albeit on a different level. Another positive instance is in the case of a client's reticence to take part actively in music due to physical degeneration, and the recognition of the frustrations that this will cause the client. Taped music can here be effectively used to offer an alternative musical experience. In a case-study validating this approach, Munroe explains how the client used taped music as a means to access his feelings of denial. The use of his own ethnic music provided a catalyst in establishing the therapeutic relationship, and in providing the trigger by which he was able to verbally share his suffering and despair.

Imagery, combined with relaxation techniques (Salmon 1988), is another approach. Salmon explains that music can be a valuable addition to autogenic and progressive relaxation techniques. Slow instrumental

music is used with little variation in dynamics and a regular slow pulse. This repetition of soothing sounds helps the client into a state of relaxation often helping him/her to sleep. Aspects of imagery during this process should be geared to the patient's needs :

"The therapist begins by asking the client a question such as : "What is the calmest, most tranquil place that you can imagine ?". Additional questions are asked to expand on the image, using as many senses as possible. This process ensures that it is the client's, not the therapist's image. This image enables clients to reconnect deeply with that which is important to them. It is a sanctuary to which they can return and which no one can take away."

After a period of relaxation the therapist travels with the client to their own personal imaginary place, exploring and sharing as far as the client is able. A tape of this process is often left with the client, enabling a repetition of the experience after the therapist has left.

Throughout all of these approaches using pre-composed music, basic selective assumptions are made by the therapist. If bed-side work is required due to the physical state of the client, then often creative music-making is inappropriate. However the choice between live or recorded music can have far-reaching effects on the therapeutic relationship. By using live music the therapist has the potential to proceed into improvisation, if this is applicable. As a passive intervention (see 1.3.5.) pre-recorded music does not provide a creative link between the client and therapist. It functions rather as a transition towards verbal evaluation. The choice of pre-recorded or live music for the dying person, should therefore be made with the greatest thought and attention.

1.4.3. Improvised Music.

Improvisation has developed as one of the main components of several major models in music therapy (Bruscia 1988). Its potential lies in the ability to relate to the client on "actual", and "symbolic" levels (Nolan 1989), and contains diverse possibilities of communication (Aldridge 1991). Improvisation in music therapy is built primarily through a medium that requires equal skills from the therapist (musical and therapeutic) in shaping and mirroring the musical relationship as a part of the client's extramusical world.

Improvisation in hospice/palliative care is used infrequently, and as a therapeutic tool is not generally considered to be of primary importance when working with clients who are in the later stages of their illness. Munroe (1984) states :

"Improvisation, which I had hoped to use often, was only very infrequently an appropriate therapeutic technique with these very ill patients."

This statement encapsulates the generally held belief that for clients who are very ill, improvisation is not an appropriate therapeutic tool. The main reasoning for this conclusion is that creativity at this stage can promote avenues of frustration. (see 1.4.2.) The author's view that this is a misguided interpretation of the possibilities of improvisation at this juncture within a client's development, due to the lack of relevant literature, can only be corroborated through this research project. The following short case-study serves to demonstrate one example :

"Colin was transferred to the residential unit, during the later stages of his illness. The sessions we shared together were strong, powerful and crucial for Colin, in expressing his feelings of frustration and anger at having to die at such an early age. In the initial session Colin displayed feelings of irritation through powerful drum and cymbal playing. This session was committed to attempting to offer Colin the space, through music, to express these feelings specifically towards me, the therapist. Therapeutically the reasons for this were that Colin needed to identify one person at which to direct these perceptions rather than be agnry with an ambiguous, undefined whole. In the second session Colin explored, in the main, verbal avenues with regard to his ensuing death, and during the third session Colin again expressed anger through violent percussion playing. In the final session Colin exhibited another side to his musical self, through a beautifully controlled piano improvisation." (Lee 1989)

It is my experience that, whilst improvisation should be offered to ill clients with the utmost care and sensitivity, it can provide the means to explore unresolved issues. Colin recognised the potential for improvisation and, whilst on the surface he was physically limited, these constraints became secondary to his psychological needs. Improvisation was offered to many people during my work with near-death clients. It was not always appropriate but when recognised as an avenue for deep levels of expression, it afforded a unique opportunity only available, in my opinion, through this form of musical creativity.

1.4.4. Summary.

Music therapy with people who are dying is a highly charged and emotive area of work, for the both client and therapist. To be effective it is essential that the therapist considers his/her own feelings about death and dying (Bright 1989). The possible romanticising of the therapist's role can have a direct effect on the therapeutic relationship. The therapist who considers that "to be involved in Palliative Care is sacred work" (Martin 1989) could be invalidating his role as a therapist with an overassessment of his own personal worth.

O'Callaghan (1989) notes that whilst the initial major writings on music therapy and the dying (Bailey 1983, 1984, 1985. Munroe 1979, 1984. Bright 1986) have provided a solid grounding of documentation and description, a music therapy framework has still to be formulated. In the United Kingdom, music therapists have been slow to be included within the Hospice Arts development ; this is due in part to the lack of a theoretical base in establishing and differentiating the work of music therapy. (Lee 1989)

In conclusion it is suggested that, whilst descriptive case-study writings are important in contributing to the documentation of music therapy in palliative/hospice care, therapists should also be considering the beginnings of various methodological criteria of their work.

1.5. Music Therapy and AIDS.

Differing practices in Europe and America have highlighted the need for a broad spectrum of music therapy services. Generally speaking, therapists in America have developed music therapy through “passive intervention”, most notably guided imagery (Bruscia 1990, 1991, 1992), whilst those in Europe have found “creative intervention”, based on the creative improvisational approach of Nordoff and Robbins (Nordoff and Robbins 1977) to be the most effective form of therapeutic procedure (Aldridge and Neugebauer 1990).

1.5.1. Guided Imagery and Music (GIM)

Guided imagery and music (GIM) is “a technique which involves listening in a relaxed state to selected music, a programmed tape or live music, in order to elicit mental imagery, symbols and deep feelings arising from the deeper conscious self” (Bonny 1978,1975,1983,1984). Guided imagery is a potent tool for addressing many of the issues faced by people living with HIV and AIDS (Bruscia 1990). In an indepth study with a single client Bruscia (1991) describes the guided imagery process, incorporated alongside extracts from the clients own evaluations described during the sessions. Bruscia discusses five “dynamic elements”: imagery, music, mandalas, the therapist’s personal experiences and the client-therapist relationship.

The effectiveness of guided imagery with AIDS depends on the maturity of the client, the capacity to be able to face childhood emotional wounds, and the openness to desired self-healing. These variables are affected by the stage of the client in the illness. Men who are asymptomatic are less likely to be prepared to enter into in-depth

guided imagery work, than those men in the later stages of the illness. (Bruscia 1990)

1.5.2. Improvisational Music Therapy.

Improvisation as a “creative intervention” for people living with HIV and AIDS provides a direct musical link between the client’s representations, and the therapist’s mirroring and reflection. Improvisation is vital in the therapeutic relationship, as it contains the ability for a mutually responsive expression of the direct issues facing the client. The musical relationship set up through a primarily non-verbal means of communication can become crucial in expressing issues, particularly of death and dying, which are too difficult or painful to articulate verbally. (Lee1991)

The following index of music therapy considerations have been developed during the author’s three years of practical work in therapeutic improvisation. The model of music therapy developed was not concerned directly with the cognitive or neurological aspects of the client, the sessions being geared towards the client’s psychological state. Whilst various categories deal with either the musical or therapeutic paradigms independently, they are not mutually exclusive in terms of the therapeutic relationship, and serve to highlight the particular aspect of the music therapy aggregate that was crucial :

- 1) The recognition and utilisation of specific musical textures as a means to explore explicit therapeutic avenues.
- 2) The use of precise instrumental combinations.
- 3) The use of a pre-determined verbal improvisational direction.

- 4) The differentiation and meaning of one complete improvisation per session, as opposed to several smaller ones.
- 5) Musical representations of Death and Dying as specific concept.
- 6) Identification of tonal and atonal parameters in validating the therapeutic process.
- 7) The use of untuned percussion in portraying issues of anger and denial.
- 8) The therapist as an "Active Listener" (see 6.1.2.3.)
- 9) The identification of "elements of communication", and their significance. (see below)
- 10) The therapist's role as being commensurate, rather than supportive.

note. "Elements of Communication" denotes those passages in the therapeutic improvisation when the client and therapist appear to be working in direct musical correspondance. The client appears, through the musical interaction with the therapist to begin to develop a dialogue with his or her own musical personality or identity. By way of the musical experience the client discovers his or her own, as yet, "unsounded music". (Lee and Carter 1989) (see 4.3.2.1. / 5.1.2.1. / 6.3.2.3.)

1.5.3. Characteristics of playing in Improvisational Music Therapy.

Generalisation of improvisational characteristics, when applied to a specific client group, should be approached with caution. Each person, and indeed each individual session, should be regarded as a unique experience, free of any overriding commonalities of musical or therapeutic proclivity. Taking the above provisos into account, it is possible to identify certain idiosyncracies of improvisational playing, taken from the author's own experience. These characteristics highlight the issues faced by people living with HIV and AIDS as

opposed to, and clearly differentiated from, other client groups in music therapy.

1) Lack of rhythmic coherence – a) aleatoric, with little regular pulse, or b) perseverative and lifeless.

note : throughout this project the term perseveration is referred to as : the meaningless repetition of a musical activity (Nordoff – Robbins 1977).

2) Musical aggression – loud playing, often over long periods.

3) The avoidance of extended melodic phrases.

4) Harmonic modalities – a preference for a) minor keys and modes, or b) complete atonality.

5) The cell and seed (see 6.2.1. and 7.2.2.) – a small group of notes which forms the central improvisational procedure.

6) Antithetical expression – the representation of differing musical polarities. (see 7.3.)

1.5.4. The Client's Evaluation.

The two following extracts have been taken from the authors work at London Lighthouse, describing music therapy from the client's perspective ;

"Through music therapy I am learning to express myself in a way that I didn't know existed. Expressing a part of me that I never in a million years thought I had. My music has become a very important part of me. When I was diagnosed as having HIV infection two years ago, I knew I had to do something about it. Music therapy has been a fulfilling, exciting and truly wonderful addition to

my life. It's added a new dimension, and has proved therapeutically to be an excellent means of alleviating stress." (Tony)

"I have been on a long journey during the past eight years, and now it is my chosen task to find a form of creative expression, in which I may find the inside of me. Music therapy for me is about a common language of understanding that will lead to the heart, leaving the intellect free to do only the work it was designed to do, as a servant of the heart. Music therapy allows me to access to a self remembering of the past data held in my mind, and it is this data that has a form and a symmetry to it. A path of random yet sequential events. Music therapy contains a very random symmetry which means that for just a brief moment you can almost see the essence coming from me." (David)

1.6. Issues Facing the Therapist.

During the stage one analysis (an idiosyncratic description), it became necessary at certain points to evaluate my own feelings and representations of the therapeutic process, in order to obtain a complete picture of the therapeutic relationship. How the events of the therapeutic alliance affects the therapist forms an integral part of the recognition of feelings as "countertransference."

HIV and AIDS more than any other illness in our present-day society has strong social and stigmatised implications, which by their sheer nature, must influence both client and therapist. This in turn will potentially affect the music therapy process itself. From my own personal experiences it is these precise political attitudes of present-day society, that determinedly affects not only the client's representation within music therapy, but the therapist's also. The

compulsion to become part of the "soap-box" petition should be addressed by the therapist in the light of such persecutory incidents as described in 1.2.4. How this is resolved within music therapy is a concern for each therapist's own conscience, both within the therapeutic relationship, and as an individual. (Lee 1989)

The therapist may experience what has been termed as the "AIDS dream" (Winiarski 1991) and/or sleepless nights. The overpowering feelings of helplessness at the recognition that the client will eventually die, and the connections between theory and reality (Ross 1969, 1987. see 1.3.1.) during the progression of the virus, can cause distress directly affecting the therapeutic alliance. Physical deterioration, possible dementia, and the potential unwillingness of the therapist to face these manifestations as a possible herald to the end of the therapeutic relationship, can bring many complex personal issues for the therapist to the fore.

As death nears, it becomes more difficult to continue the regularity of sessions. The client may become hospitalised or too ill to attend. The therapist can now experience new anxieties. The not knowing whether or not the client will attend the session, and the possibility that in fact they he/she have died. At this time there is the possibility that the client may become distanced, which may raise issues for the therapist of rejection, both personally and for the sessions themselves. Saying goodbye can have lasting repercussions for the therapist. How is the subject broached and what words are adequate to express the end of a relationship ?.

It is essential that any therapist working with people living with HIV and AIDS, should have his/her own regular counselling/supervision.

Chapter Two.

Aspects of Improvisation and Music Therapy.

2.1. Introduction.

This chapter will begin with a concentrated review of the theories and concepts of western improvisation since 1934. It will discuss and evaluate improvisation in terms of "Art", process, and interaction, suggesting the need for therapeutic improvisation to be considered as an integral part of future proposed theoretical studies. An evaluation of the major models of therapeutic improvisation will highlight the above disparity, the literature containing a singular lack of constituent explanation. The musical elements of therapeutic improvisation will be briefly discussed through the author's previous studies, culminating in a critical questioning of the efficacy of "outcome" research designs. The chapter will conclude with a brief examination of the reasoning and differentials between the three core-analyses in part two.

2.2. Studies and Meanings.

The variety and diversity in the interpretation and practice of music improvisation has led to a disparity in theoretical frameworks. The differences have arisen from basic core assumptions, which are often self-contained in definition, and subsequently not compatible in conceptualization.

Studies dealing with improvisation can be divided into four groups.

1) The tonal infrastructure (Bregsen 1960, Sperber 1974, Stumme 1972, Whitmer 1934). These texts are analytical in design.

2) Free Improvisation (Alperson 1984, Briggs 1986, Ferand 1938, Goldstein 1983, Jost 1974, Netti 1974, Prevost 1985, Solomon 1986). This material is more subjective and descriptive in content.

3) Special journal editions. i) Perspectives of new music (Fall - Winter 1982/Spring - Summer 1983. pp 26-111). ii) Music Educator's Journal (1980. 66 (5) pp 36-147). iii) Keyboard (1984, 10-10). iv) The British Journal of Music Education (1985, 2-2).

4) Theoretical aspects (Pressing 1984, 1987, 1988, Dean 1989, 1992, Johnson-Laird 1991). This work deals with the computational and possible scientific analysis of improvisation.

Etymologically "improvisation" is derived from the Latin past participle, "improvisus". (related to the verb, "providere", "to foresee") "Improvisus" refers to that which has not been foreseen (Durant 1984). The word developed in the Italian and French languages, the verb "improviser" meaning "to act without foresight or foreplanning", this term often being connected with some form of artistic expression. In English the word was initially used in the late eighteenth and early nineteenth centuries to describe an unpremeditated musical activity more commonly known as extemporisation. By the late nineteenth century, the word had developed in meaning to include the act of "doing things spontaneously".

2.2.1. Improvisation as Performance.

Lack of specificity in terminological definition has contributed to the misunderstanding of improvisation in terms of intention and content. The term performance, in general terms, can be described as an “accomplishment”(Ed Watson 1976), though when ascribed to music its definition is more specifically connected with a previously rehearsed production before an audience. Which of these interpretations is meant, is not made clear in the following dictionary definitions :

“Improvisation is the art of thinking and performing music simultaneously” (Ed Blom 1961)

note. In the New Grove Dictionary of Music (Sadie 1980) improvisation is given greater prominence with an article on western and eastern improvisation. However free improvisation is discussed only in the context of the seventeenth to nineteenth centuries. It is not included in Jazz and is mentioned only in passing on the section devoted to aleatoric music.

“Improvisation is performance according to the inventive whim of the moment” (Kennedy 1980)

Neither statements provide satisfactory explanations for such a complex musical procedure, and it would appear significant that the word “whim”, meaning something that is impulsive or irrational, is attributed so lightly.

Nattiez (1990), from a semiological viewpoint, describes the fundamental aspects of improvisation as being “the simultaneous performing and inventing of a new musical fact with respect to a previous performance”, whilst Solomon (1986) defines these as “the discovery and invention of original music spontaneously, while performing it, without preconceived formulation, scoring or context.”

2.2.2. Improvisation as Invention.

With the emergence of “completely free”, “collective improvisation” or “spontaneous music”, in Britain, Europe and the United States, (Parker, Bailey, Riley, AMM, and Taylor) improvisation became more flexible and open. These developments can be paralleled with the work of peer composers engaged in the contemporary concert environment.e.g. Stockhausen, Cage, Cardew and Boulez.

Derek Bailey (1980) describes improvisation as needing no argument or justification. “It exists because it meets the creative appetite..... and because it involves (the musician) completely, as nothing else can, in the act of music-making.” He further goes on to propose that “improvisation means getting from “A” to “C” with no “B”, it implies and requires a void which has to be filled.” These descriptive comments serve to widen the possibilities of definition, without projecting authoritative explanations of meaning. Riley simply calls improvisation “the exploration of occasion”, whilst Smith in a more formal explanation describes it as “the ability to instantaneously organise sound, silence and rhythm with the whole of his or her creative intelligence.” Two recent personal representations, through interview, are worth considering; Maya (1992) describes improvisation as “a state of mind. It’s simply what you hear and do at the moment”, and Hosinger (1992) remarks that “you think about something, you see something, and then you operate, you have the flash, like an abstract picture, and then you present it.” Whilst these reflections may be considered esoteric and vague in content, what they do provide is a more exploratory perspective of the dynamics of improvisation.

2.2.3 Improvisation as Process.

Pressing (1984, 1987, 1988) describes the processes involved in improvisation as containing “seeds”, which are held together as a set of “event clusters”, and from which a musical direction is developed. From various options the improviser may continue a musical exemplar, described as an “event cluster”, by developing various similar criterion such as key centre and rhythmic pulse, whilst changing another major parameter. This is described as an “association of array entries”, the discontinuance and contrast of which are heralded by a new category of “array entries” or “musical parameters”. This subsequently creates new “event clusters”, derived from the preceding transposition of data. Clarke (1988) discusses two further ways of organisation :

“the first event may be part of a hierarchical structure, to some extent worked out in advance and to some extent constructed in the course of the improvisation.”

The generation of structural invention must be related to the creative design. In terms of therapeutic and free improvisation there may be little or no musical plan, the hierarchical fundamentals taking their foundations from the opening motivic germs which are then developed throughout the improvisational structure.

Pressing (1984), in his study of improvisation as “performance”, proposes two aspects of structure “feedback”, and “feedforward”. He suggests that ideas are developed by “continuous aural and proprioceptive feedback which allow continuous evaluation, on the basis of which the current ideas are either repeated, developed or discarded.” Feedback is concerned with error correction, whilst feedforward considers future events, providing a balanced structure of decision-making and design.

2.2.4. Improvisation as Interaction.

"Improvisation is less centred on any actual arrangements of sounds than on forms of human relationship and interaction, on kinds of decision making and collective problem-solving." (Durant 1984)

Durant emphasises the inter-personal relationships of the improvisors as holding equal importance to the actual artistic production. He discusses definitions of "problem" and "solution"; "what may seem a problem to be overcome by one player may well seem a point of comfortable equilibrium to another." He explores these concepts from both musical and personal angles, discussing human relationships and conflict in terms of the direct improvisation. His argument becomes unclear when he attempts to categorise improvisation as being an essentially pleasing experience, thus potentially invalidating one element of his hypothesis.

The interaction set up in improvisation, emanating from the improvisors themselves and their own personal issues, rather than from the music itself as an independent exemplar, is a facet that concerns many present-day improvisors. Prevost (1984) states that ; "Improvised music is a music of self-definition", and that improvisation exists "because there is no satisfactory formal means of expression to convey much of the contemporary human experience." Hosinger (1992) compounds this view ; "it seems to me to be important in a socio-political way, regarding how we feel about the times we live in." Berendt (1985) states that "the improviser listens - firstly - to the people improvising with him, to his fellow human beings. The composer is alone. The improviser is part of the community." These powerful comments would suggest a searching of human expression not

ultimately acknowledged in the boundaries of this style of improvisation. Dean (1989), discusses personal character in improvising, but fails to find a balance between personal expression and what he terms the "improvisers attitude towards the audience". It is this quintessential aim of improvisation, and the ultimate prerequisite of an audience, that does not allow for indepth personal expression.

Therapeutic improvisation appears to be a separate and distinct form of creativity in terms of professional knowledge. Durant(1984) suggests that improvisation when used as a human potential may be "even therapeutic", and Bruscia (1987), in his comprehensive catalogue of improvisational models of music therapy, makes no mention of other forms of improvisation. The differential core lies in the fact that therapeutic improvisation's primary aim is not to produce "art", nor is it normally produced with an audience. Music therapists do attempt to produce music of artistic quality, though the overriding aim of therapeutic improvisation is that of the client and the relationship that is set up through music.

It would seem clear that discussion and examination of procedure, contained between both improvisational ideals, would provide productive reciprocal feedback. The interactional elements contained within improvisation form the essence of creative production (Aldridge 1989), they allow a personal manifestation of musical expression that is at the heart of all improvisation. Whilst the aims and endeavours of each may be different, the overriding creative core is identical. It is this core that challenges all improvisational approaches to share and assimilate aims and objectives.

2.2.5. Expertise and Musicality.

Sloboda argues that ;

**“What distinguishes improvisation from composition is primarily the pre-existence of a large set of formal constraints which comprise a “blue-print” or “skeleton” for the improvisation.”
(Sloboda 1985)**

Lockett (1988), and Zinn (1981) propose that improvisation is about skill acquisition and accomplishment. Zinn further goes on to expound his belief that to reach the stage of “pure conceptual reproduction”, the improviser requires years of practice. Robinson (1990) augments this theory by stating that “intensive rehearsal also reinforces the cognitive link between the mental intention and physical execution of the musical figures.”

The counter-arguments of this assumption are relevant both to the preceding sections of this chapter (see 2.2.1. and 2.2.2.), and the project as a whole. Why is an improvisation generated (for an audience or the improvisers themselves), and how important is musical skill in the end product ? The main hypotheses of the above statements are linked to aspects of improvisation as “art”, ignoring elements of personal experience and evaluation during the improvisational process. In terms of music therapy, and the contents of this research, the distinction can be clearly affirmed. There are no formal constraints within therapeutic improvisation, and expertise is not a pre-requisite. The crucial assumption of this argument centres on the authors hypothesis that “quality of musical content within improvisation is not always automatically linked with musical expertise or knowledge”.

Derek Bailey found that by introducing non-improvisers into his group, the improvisations themselves took on new dimensions. He noted that "it's not very difficult for the non-improvisers, listening and getting involved in the music, to sort out the various things that might happen." The connections with therapeutic improvisation are again relevant, as for the most part, the client may have limited musical knowledge. Both instances would presume an imbalance in improvisational expertise. In real terms, however, the formal musicality of the improvisers becomes secondary to the directive flow of the music, providing a platform that allows for equality of content.

Eddie (see chapter four), as an untrained musician, had experience of both improvisation and therapeutic improvisation. He comments on how music therapy enabled him to be more confident in other forms of improvisation:

Note. It should be explained that the client Eddie, described in chapter four and throughout the project, bears no relation to Eddie Provost the musician.

"In a lot of improvisations I've been involved in before, there has been an element of "I don't want this person to think I'm naff, and I want this to work because I want to be a musician." There's all these things going on when I improvise with other people. When I started working with you I thought, "He's a music therapist, I can do exactly what I like and it won't matter". That's why I was so challenging at the beginning, and in a way that freed me up quite a lot. I think it changed my feeling of what I could or couldn't do, I always knew that there were whole areas there that I could get involved in that I thought were valid, in the areas of aleatoricism, the world of atonality. But I tended to be a coward by others lack of adventure. Music therapy freed me up to think that it was

available, AMM affected that as well. In many ways it doesn't matter what you play as long as it is sincere." (Eddie. Assessment session)

Note. AMM is an improvisation group which began performing in 1965. (see 4.1.1.)

2.2.6. Conscious and Subconscious Elements.

The conscious and unconscious act of musical improvisational gesture has always been open to speculation. Johnson-Laird (1991), states that in improvisation the essential psychological feature is that "the musicians themselves do not have a conscious access to the processes underlying their production of music." He further goes on to explain his belief that as human beings, we only have access to a small part of the contents of our minds, and hardly any to our mental processes. The unconscious components of improvisation are highlighted by "the very existence of cognitive psychology." This view is corroborated by Konowitz ; (1969) "the improviser, functioning simultaneously as performer and composer, explores conscious and developed skills while he strives to unearth relationships which may be part of the unconscious."

An opposing semiotic view would seem to suggest that elements of consciousness are considered to be authoritative ; "the improvised construction goes through a precise act of will ; improvisation brings into play a certain level of consciousness that may emerge as explicit indeed as verbal." (Lortat-Jacob 1987) This perspective is compounded by Nattiez (1990), who, whilst on one hand acknowledging the broader possibilities contained within improvisation, cites mainly ethnomusicological investigations to corroborate his claim that improvisation is principally based on both well-defined models and the

performer's own physical routines.

In terms of music therapy it is suggested that the unconscious elements of improvisation are often more important than the conscious aspects. Bruscia (1987) classifies the elements of therapeutic improvisation thus ; "Conscious components are those aspects of the improvisation that are kept in awareness and directed with purpose. Subconscious components may include anything that the improviser does not keep in awareness or direct purposeful intention." The ability to describe, and/or be aware of the therapeutic significance, when an improvisation is conscious or subconscious, has been examined by Pavlicevic (1988) (Critical moments), and Lee and Carter (1989) (Elements of Communication) (see 1.5.2.). Whilst neither are able to categorize clearly (for where does consciousness end and subconsciousness begin ?), they do raise questions as to the need to identify more clearly the musical and therapeutic consequences contained within either form of expression. In the investigation of the Generative Cell (see 6.2.1.), the terms "Intended" and "Involuntary" have been incorporated to designate the possible differential usage of the conscious and subconscious cell as an improvisational procedure.

2.3. Models of Improvisational Music Therapy.

The purpose of this section is to summarize the major models of Improvisational music therapy. The review has been divided into two sub-categories : Core Models - where the central music therapy progression is improvisation, and Component Models - where improvisation functions as one part of a broader application. Whilst hardly any of the literature mentions the actual improvisatory musical components, it is necessary to outline the main hypothesis of each

approach.

2.3.1. Core Models.

This section is comprised of the four main core models of improvisation developed in Great Britain.

In order to collate and compare the quintessential elements contained within the core models, the components have been coordinated in tabulation form. (see Figure Three) Each method is categorised under the following classifications :

- 1) Central aims.
- 2) Client groups.
- 3) Individual/group.
- 4) Improvisational components.
- 5) Facets of the music therapy process.

2.3.2 Component Models.

i) Experimental Improvisation Therapy - This approach was initially evolved as a means for handicapped people to explore through dance, and was later developed, in terms of music therapy, by Bruscia (1987) Through the group situation it aims to enhance the potential for self-expression and creativity, to develop individual freedom as an individual within the group and as an integral part of the group

Figure Three. Core Models.

Component
Classifications.

Creative Music Therapy
(Paul Nordoff and Clive Robbins 1965,1971,1977,1983)

1. a) To develop self-expression.
 b) To promote communication and Human relationships.
 c) To cultivate personalities.
 d) To strengthen creativity.
 e) To disperse behaviour associated with pathology.
2. Handicapped Children.
3. Individual and Group.
4. Therapist – piano – improvisational components based
 on Musical Resources.
 Client, and co-therapist – voice, drum and cymbal.
 Other instruments added as necessary.
5. Stage one : Meeting the "music child".
 Accepting and complementing the child's expression of
 its emotional position. Musical contact, and
 exploration. Developing the relationship.

 Stage two : Evoking musical responses.
 Techniques of response stimulation through presenting
 instruments, improvisation, turn-taking and shaping
 of musical inventions. To provide the child with a
 musical vocabulary for self-expression. To establish
 the client/therapist relationship.

 Stage three : Developing musical skills, expressive
 freedom and interresponsiveness.
 Encouraging a regular beat, exploring rhythmic
 patterns/ melodic motives. Freedom through musical
 skill – "interresponsive", relationship with the
 therapist.

Free Improvisation Therapy.
(Juliette Alvin 1975,1976,1978)

1. a) Self-liberation.
 b) Developing of relationships.
 c) Development growth – physical, intellectual,
 social-emotional.
2. Handicapped children.
3. Individual and group.
4. No rules. The client explores and orders through
 Improvisational freedom.
5. **Stage one** : Relating self to objects.
 "Active" – relationship to music and instruments.
 Sensorimotor, perception and integration.
 "Receptive" – The client is introduced to the
 instruments. Nondirective.

 Stage two : Relating to self and therapist.
 "Active" – Projection of feelings onto instruments,
 development of trust with the therapist.
 "Receptive" – Listening to explore the clients
 awareness.

 Stage three : Relating self to others.
 Development from the individual to group setting.

Analytic Music Therapy.
(Mary Priestly, 1975,1980)

1. To eliminate obstacles preventing the client from attaining his/her full potential, and personal goals.
2. Adults with emotional or interpersonal problems.
3. Individual and group.
4. Words and symbolic improvisations. The clients improvisations are often prompted by verbal discussion and emotional specification.
5. **Stage one** : Identify the issue. Verbal discussion or untitled improvisation. (body language)
Techniques for a) accessing unconscious material, b) exploring conscious issues, c) strengthening the ego.

Stage two : Defining the improvisatory roles of the client and therapist. Variables : a) the therapeutic issue b) role possibilities in the title c) techniques of the therapist d) the client's need for direction e) the client's readiness.

Stage three : Improvising the title, "inner music" - the client improvises either alone, or with the therapist.

Stage four : Discussing the improvisation. The client's verbal reflections. The therapist interprets. Possible re-cycling of the stages.

Psychodynamic Directed Music Therapy.
(Pamela Bartram 1991, John Woodcock 1992)

Personal Growth – Development of interpersonal and intrapsychic relatedness. Events within the session (including the therapist's internal responses to the client) are informed according to psychodynamic theories, and mother/infant interaction studied from both developmental psychology and analytic perspectives.

- 2. All client groups.**
- 3. Individual and Group.**
- 4. Largely free-improvisation, on and with the client's behaviour (musical or otherwise), and taking account of the therapist's counter-transference. Music may be pre-composed and structured in accordance with the needs of the client. Therapist's musical output is informed as in (1), and by his/her musical experience, musical personality and understanding of music in societies.**
- 5. Reverie. Listening and allowing the internal musical world to resonate with, and respond to that of the client. Holding and containing.**

Empathy and unconditional positive regard.

Reflection and variation.

Playing and Creativity. A play space in which to be creative. Play as a meaningful means to explore emotional experiences. Play as dream.

and to build “physical, social, emotional, cognitive, spiritual and cognitive skills inherent in music and dance.” The therapeutic procedure is conducted in terms of “procedural cycles that are repeated until a complete improvisation is fully developed, rehearsed, and ready for performance.” (Bruscia 1987)

ii) Orff Improvisation Models. - The original “Orff-Schulwerk” philosophy of music education was adapted, in terms of music therapy, by C.Orff (1980), Bitcon (1976), and Lehrer-Carle (1971). “Elemental music”, the inherent disposition to create music from natural rhythms in movement and speech, is the essential core from which the music therapy approach developed. There is no one clear therapeutic procedure, and group work is the most commonly formulated therapeutic construction. The stages of each session normally begins with a “warm-up”, followed by a “germinal idea” suggested by the therapist. The activity is coordinated by the therapist, afterwhich the “germinal idea” is explored, followed by a formalised exploration of the event. This construction can accomodate the whole session, or may be repeated.

iii) Paraverbal Therapy - Heimlich (1965, 1972, 1980, 1983, 1985) developed a form of verbal and non-verbal psychotherapy, utilising various forms of expressive avenues (speech, music, mime, movement, psychodrama, art). It is used mainly with children who have emotional or communication problems and its main aims are to satisfy the child’s emotional needs, develop a sense of self, cultivate communication and self-expression, and to afford relief from symptoms and painful experiences. The four stages of the therapeutic process : observation, manoeuvre, shift, and encounter provide the opportunity for the therapist to begin to understand the child’s situation. The therapist

must then decide whether or not the child is able to experience an “encounter” whereby the child is confronted with his/her problem.

iv) Integrative Improvisation Therapy – Simpkins (1983) formulated an approach with children, the main aims of which were to assimilate various aspects of the child's existence. The therapist uses verbal and musical paradigms (piano and voice) via four stages or intentions. Disclosure is facilitated through an open therapeutic situation, the therapist waiting and “attending”, helping the child to “work through” his/her problems musically and verbally.

v) Developmental Therapeutic Process – Developed by Grinnell (1980) this model is used with emotionally disturbed or psychotic children. Its main aims are to “develop interpersonal relatedness through nonverbal and verbal modalities, and to work through emotional conflicts, symptoms and developmental obstacles.” (Bruscia 1988) The three stages of therapeutic process are developed from musical improvisation, through to an exploration of non-musical avenues (art, drama, verbal discussion.)

2.3.3. Improvisation Assessment Profiles and their Relevance in Analysing Therapeutic Improvisation.

Improvisation assessment profiles (IAP) were developed by Bruscia (1987) in an attempt to present a complete model of assessment and evaluation. The three stages of investigation : observation, musical analysis and interpretation, are significant in that they establish the musical components of therapeutic improvisation as containing the essential modalities of assessment. The first stage observes the client

within various musical and therapeutic situations. The second stage analyses the improvisations commensurate with a set of profiles and subscales, and the third stage is an interpretation of the findings in relation to a particular psychological theory which is applicable to the client's condition.

There are six profiles that contain subscales for each musical component ; Integration, variability, tension, congruence, salience, and autonomy. Each profile concentrates on one musical process with a continuum of five gradients : undifferentiated, fused, integrated, differentiated and overdifferentiated. Every subscale concerns itself with how the process is noticeable in each musical feature.

Through critical evaluation of the analysis elements of IAP's, in my view, the main area of contention is concerned with the actual form and content of the analytic procedure, and the subsequent analysis itself. To begin in broader terms, it seems incongruous that a comprehensive encyclopedia of improvisational models written by the creator of IAP's (Bruscia 1987) includes and makes no reference to musical examples. This observation is carried forward in the musical analysis of stage two ; Bruscia gives no guidelines for notating the improvisation in musical tabulation, and throughout the subscales of the six profiles, affords no examples of musical format, discussing the musical components in terms of generalised component proclivities. This major omission, in terms of the actual specific musical content of therapeutic improvisation, would suggest that the assessments are considered in terms of other paradigms and not at any stage as constituents in their own musical terms.

2.4. The Musical Components of Therapeutic Improvisation, and their Significance in the Investigation of Music Therapy.

Through my own initial investigations of the analysis of therapeutic Improvisation (Lee 1989, 1990) many questions came to the fore. The conviction that musical constituents should be considered with equal weight to avenues of therapeutic investigation, and that pre-composed music and therapeutic improvisation contain similar essential musical *nuclei* evolved as the main analytic conclusions :

"... music therapy research should be fundamentally addressing issues of speculative analytic investigation alongside the complex behavioural responses that have preoccupied many research projects to date." (Lee 1989)

"Analysis of musical content within therapeutic improvisation demonstrates that the improvised moment, however chaotic it may at first appear, can have a structure in exactly the same way as a pre-meditated composition. An improvisation survives and exists for as long as it occurs, whereas a composed piece of music has been crafted and designed to a preconceived level by its creator. Perhaps the differences are not as great as they would at first appear ; both have an underlying unity of conception. One is acclaimed as being from the pen of an artist, the other as the chance product of a therapeutic situation. One is written by a supposed "normal" person, the other is not. Are therapeutic improvisations then comparable to present-day works of Art ? To answer this question is not to compare quality of musical content alone, but also, musical intent and direction. A music therapist may have no wish to pose as a composer and vice versa, but if what both are creating and

saying can be shown to be subject to the same structural considerations and inner relationships, then such analytical insights should be fundamental in the furtherance of music therapy. (Lee 1990)

The assumptions concluded through these initial investigations were compounded throughout this project. The musical content of the three improvisations, combined with the therapeutic direction, provided a wealth of intricate musical components comparable to the accomplishment of pre-composed music.

2.4.1. Problems of Transcription.

One of the main problems facing the music therapist who wishes to investigate the musical processes of therapeutic improvisation, is musical transcription. Until the availability of a computer assisted piano, utilised within this project, notational procedures had to be achieved aurally. Even with this relatively new development, there is still no way of including other instruments within the score. The confines of producing accurate data has meant that aural representations have been concerned with the broad musical outlines of the improvisational content. (Rudd 1990) In terms of future research, it would appear that if exact transcriptions are to be extracted then a computerised systematic programme needs to be developed that will take its notational print-out directly from audio documentation.

2.4.2. Modalities of Research.

That music therapists, in terms of research, have concentrated on avenues of outcome and verbal inquiry, needs to be questioned. Why is there such resistance to musical process research ?, and what does it say about music therapy in general terms, that we are so reluctant to

investigate our own quintessential paradigm ? It could be argued that this research project is equally invalidating music therapy by taking its main impetus from avenues of musical content. The concept that music therapy research should be formulating its methodological approaches from both avenues of outcome and process (Bunt 1988, 1990. Odell 1989) (see introduction) would seem to provide a balanced way forward. Can this be achieved, however, until an equal amount of process research is documented, from which the above ideal can be formally systematized ? It is the author's view that the music therapy profession has yet to become secure enough within its own research and practice to ignore any one particular avenue of enquiry.

As an initial concern, through music process research it is possible to redress the imbalance of music therapy questioning. Taking this one stage further, it could be stated more emphatically that the investigation of musical components within therapeutic improvisation holds the essential key for fully understanding the music therapy process itself. The music therapist's main concern is for the client. In terms of research the question should be "what can we discover that will give us a greater understanding of the music therapy phenomenon ?" Outcome research, in isolation, validates and consequently enables more work to be initiated, though in terms of refining therapeutic evolution, I would suggest its core is questionable. Process research is concerned with the micro-examination of the parts that go to make up the whole, thus crystallizing and perfecting the actual practice itself. Through a greater understanding of music therapy, process research returns to the client a more perfected music therapy procedure.

2.5. Stages in the Analysis.

Throughout these initial two chapters reviewing the literature on terminal illness and improvisation, it became necessary to question both the lack of theoretical framework in working in hospice/palliative care, alongside the prevalence of outcome orientated research. One of the main problems faced by the researcher investigating a duality of approaches, is the general inappropriateness of methodological frameworks. It could be argued that in terms of hard-line research the use of anecdotal material is insufficient to obtain conclusive results. (Bunt 1985) Is it therefore legitimate to complete a music therapy project that is not immediately concerned with justifying, in terms of statistical data, a conclusive outcome ? The information gained from the external validators if viewed as essential data, is indeed anecdotal in content. In defence of the analytical approach of this project, the verbal assessments were collected in terms of placing the musical parameters within a therapeutic context. The content of this research, therefore, has taken the first tentative steps to exploring and formulating a music therapy methodological framework, established from, but not reliant on, the boundaries of other systemized research philosophies.

There are three main analyses contained within the rest of this study. The boundaries of the methodological context were formalised in a purposefully unrestricted manner. The reasons for this choice emanated from the following precepts :

- a) that each client was at a different stage within the progression of the virus.
- b) that each client had differing musical abilities.

c) that each improvisation had a different therapeutic meaning and context for the client's growth.

d) that each improvisation had its own unique musical language and content.

The differential in each individual frame of reference, was chosen so as to provide the most comprehensive view of musical aptitudes alongside stages of health. The reasoning and pretext for the choice of clients is briefly outlined below under the headings health and musical aptitude :

1. Eddie.

Health - HIV diagnosis, asymptomatic.

Musical aptitude - No formalised musical knowledge.

2. Charles.

Health - HIV diagnosis, experiencing symptoms.

Musical aptitude - Limited musical knowledge.

3. Francis.

Health - AIDS diagnosis, in the last stages of the illness.

Musical aptitude - Professional musical standard.

One of the major problems encountered throughout this project was the fact that my role as therapist and researcher was combined, thus the total elimination of subjectivity was impossible. In order to situate clearly my own influences within both the research, and the subsequent effects it had upon the therapeutic relationship, personal

evaluations needed to become an integral part of the proceedings as a whole. It is hoped that many questions will be raised during the review and findings, and that indeed this project as a whole, with all its limitations and dilemmas, will provide a forum of debate, for the possibilities of new avenues of research in music therapy.

Chapter Three.

Experimental Procedure and Methodology.

3.1. Clinical Placement.

The chosen client group for this project are people living with the virus HIV and AIDS. All sessions were held at London Lighthouse. I worked one day a week for three years. Whilst all the data collected for chapter four was completed by the end of the second year, it was crucial that I continued my work as a music therapist, a) for the ongoing clients and b) to afford a broad overview of therapeutic intervention necessary for the project as a whole. The session content of each week varied during the three years, depending on the number of long-term clients and the health of the people requiring music therapy on the hospice/palliative care unit (the residential unit). Generally speaking there would be an average of four long-term clients (one-hour sessions) with two hours spent on the residential unit. Due to the health and emotional difficulties of people who were very ill and/or near death, it was decided not to include them as a part of the indepth analysis of chapters four to six.

London Lighthouse, (a centre for people facing the challenge of AIDS) is Britain's first major residential and support centre for people living with HIV and AIDS. The centre is committed to providing the best possible care, support and facilities so that people affected by AIDS can live. (Lighthouse 1989) London Lighthouse is committed to becoming an Equal Opportunities organisation and opposes all forms of discrimination faced by people with HIV and AIDS, black people, women, drug-users, lesbians, gay men and people with disabilities. The

implications of a clear non-judgemental approach regarding people (Dinnage 1990) was acutely conducive to my own work as a music therapist.

London Lighthouse provides approximately twelve holistic disciplines, enabling the service user to develop through varying forms of therapeutic intervention appropriate for each individual's needs. Most people requested music therapy through either self-referral, or cross-referral from other therapists. All complementary therapists meet on a regular basis to discuss their work, and individual counselling/supervision was provided weekly.

3.2. Prior Investigations.

Before the structure of the research methodology was evolved, two analytical papers were written, looking at the differing approaches of music analysis and their potential for the investigation of therapeutic improvisation (Lee 1989, 1990. See appendix volume two). Two improvisations from music therapy sessions with a single client with Down's Syndrome were chosen ; one tonal in design, and the other post-tonal. Both improvisations displayed differing therapeutic responses. The main aim of both papers was to explore the musical components and the potential structure that lay behind the therapeutic improvised act.

In terms of analytical design the concept of adapting procedures initiated for pre-composed music proved to be complex in correlation. The indepth musical analyses evaluated during this project are of a kind normally applied to pre-composed rather than improvised music. The intricate musical detail discussed is not bound within any

particular analytical design, but is contained within a much freer approach. For the purposes of this project it was decided to elect a methodology that would fit and answer the questions posed, rather than to try and adapt a musical formula that in essence relates to only one aspect of the therapeutic improvisation (the music).

3.3. Method.

The apparatus used in this project centred around a Yamaha MIDI – Grand Piano situated at the City University, London. It is a piano fitted with electronic sensors on every key, with MIDI ports to transmit the information to another MIDI – compatible instrument. The piano was linked via a MIDI cable to an Apple Macintosh computer, which was recorded using the Opcode 2.6. Sequencer software. Simultaneous to this, a further recording was made on a DAT taperecorder. The original sequences were converted into “standard MIDI files”, transcribed via the Finale 2.0. software package.

One of the main limitations of this transcriptional format is the notational layout received after the full programme has been completed. The Finale 2.0. software package will only receive and transcribe the information in terms of a pre-determined time signature, (for these experiments 4/4 was chosen) thus changes in tempo appear as multi-complex notation. This difficulty in relating, what will be described as the “hard core” data, to the audio recording meant that all the music had to be re-transcribed aurally from the recordings, in order to produce musical notation that would accurately represent the musical content itself. The difficulty in reading the computer print-out hard core data, can be seen by comparing a section of an improvisation in both transcriptional formats. (see Figure Four)

Note. a) Bar-lines and key signatures have been added to the score from the audio tape. They should be regarded as the researchers subjective representational guidelines, and have thus been added in brackets and dotted lines.

b) Accidentals have been retained on the score as produced via the computer print-out (hard-core data). They have not been altered to fit any inferred tonal centre and they apply only to the notes they precede.

c) Dynamics were incorporated from the audio data.

3.4. Formulation of the Methodology. Boundaries of the Analyses.

The decision to investigate three individual improvisations originated from, in broad terms, the improvisations that were occurring during my work as a music therapist at London Lighthouse. The quality and content of both the musical and therapeutic avenues appeared to be very dense and concentrated in format. Rather than attempt an overview of a whole series of improvisations, it was decided to ask each of the three clients to select one of four improvisations transcribed on the MIDI - Grand during a one month period.

The analyses in chapter four consists solely of piano improvisations. Whilst this was not representative of the therapeutic procedure as a whole (percussion instruments being incorporated often), because of research specifications and problems of aurally notating extra instrumental lines amongst the often complex music, it was decided to confine this study to piano improvisations alone. The single improvisations chosen take the following forms : 1) Eddie - Treble, Therapist - Bass 2) Charles - Bass, Therapist - Treble. 3) Francis - solo.

HARD CORE DATA

TRANSCRIPTION

(0:40) Lit

ped.

93 5

(0:44)

6 3 5

(0:49)

5

Detailed description: This is a handwritten musical score on a single page. It is divided into two main sections: 'HARD CORE DATA' and 'TRANSCRIPTION'. The 'HARD CORE DATA' section at the top consists of two staves of music. The 'TRANSCRIPTION' section below it contains three systems of music. The first system is marked '(0:40) Lit' and includes a 'ped.' (pedal) instruction. The second system is marked '93 5' and shows a sequence of notes. The third system is marked '(0:44)' and includes a double bar line. The fourth system is marked '(0:49)' and shows a sequence of notes with fingerings '5', '6', '3', and '5'. The score is written in a clear, legible hand with some corrections and markings.

Figure Four.

Handwritten musical score system 1. The system consists of two staves. The upper staff contains a melodic line with a triplet of eighth notes marked with a '3' above it. The lower staff contains a bass line with a few notes.

Handwritten musical score system 2. The system consists of two staves. The upper staff has several measures with rests and some notes. The lower staff has a few notes, including one marked 'ped' (pedal). Above the system, there is a handwritten time signature '(0:54)'.

Handwritten musical score system 3. The system consists of two staves. The upper staff contains a melodic line with a triplet of eighth notes marked with a '3' above it. The lower staff contains a bass line with a few notes.

Handwritten musical score system 4. The system consists of two staves. The upper staff contains a melodic line with a triplet of eighth notes marked with a '3' above it. The lower staff contains a bass line with a few notes. Above the system, there is a handwritten time signature '(0:59)'.

Handwritten musical score system 5. The system consists of two staves. The upper staff contains a melodic line with a triplet of eighth notes marked with a '3' above it. The lower staff contains a bass line with a few notes.

Handwritten musical score system 6. The system consists of two staves. The upper staff contains a melodic line with a triplet of eighth notes marked with a '3' above it. The lower staff contains a bass line with a few notes. Above the system, there is a handwritten time signature '8:12'.

Special note must be made of the disparity between the different musical roles, and the possible effects this decision had on the research findings. The fact of the therapist and client taking both the treble and bass lines (Eddie - treble, Francis - Bass), would appear to be balanced in format. The differential in the solo improvisation (Francis) however produces a more noticeable imbalance. Within this analysis there could be no investigation of the relationship between therapist and client, in the formal sense. This having being stated, during the research trials it was made clear to each of the three clients, that it would be their ultimate decision as to which improvisation they felt was the most valid to be analysed. Whilst this disproportion caused many problems, it was essential that the client felt empowered to make the final analytical decision. In terms of sub-results this disparity highlighted the problems of this project and the precondition that when researching the therapeutic intervention, the research format should conform to the needs of the client and not the research project itself.

3.4.1 Research Location.

Inherent when working within the therapeutic setting are considerations of boundaries, and the effects they potentially have on the therapeutic outcome. All sessions prior to the data collection were held in the Ian Mackellen hall at London Lighthouse. The change of location to the City University, plus the knowledge that the sessions would be a part of the forthcoming research project, created changes in the therapeutic alliance that could have direct repercussions on the findings of this study.

In real terms the actual improvisations were clearly representative, for all three clients, in terms of their therapeutic development. The only visible differential that I noted, in my role as therapist, was a slightly greater concern with the actual musical elements of the improvisations.

3.4.2. Quantative and Qualitative Aspects of Interpretation and Design. Problems of Verbal Validation and Assessment.

The initial impetus of this project was to investigate the possible correlation between music therapy and aspects of psychoneuroimmunology (see 1.3.3.). The potential quantative approach required large control groups which could be used in standardised outcome research methodologies. This approach was abandoned in favour of a small intensive study essentially descriptive and qualitative in design. The reasoning behind this change of direction came from the desire to investigate the micro-processes of the essential musical dialogue. The depth of analysis meant that a small control-group would be necessary, subsequently procluding outcome and quantative interpretation.

In order to contextualise the stages of each analysis verbal reflections were collected and collated from the client and three external validators. The problems that arose in electing this conceptualisation of introducing elements of subjectivity within the research design, dealt with the necessity and potential of "blind" outside information (data). It was impossible to find a music therapist who was not aware of my work in HIV and AIDS. The information collected could therefore be seen to be imbalanced from that of the counsellor and musician. The question that is highlighted from this

enforced disparity is ; how essential is it that the outside assessments be strictly blind ? Therapeutic improvisation deals with musical expression and creativity that is intrinsically personal and which often expresses a communication at a very deep level. The audio recordings must be therefore viewed as second-hand (see 6.4.). In terms of the imbalance of assessors and the questionable need for strict "blind" data, the information acquired was used freely and creatively within the structure of the research project as a whole.

The client was asked to return to the university, to listen back to the chosen improvisation. The guidelines for stopping the tape and making comments was based on the simple proviso that they felt either *something important had happened, or that they had something to say in general terms*. The assessment was conducted in the form of a discussion between myself and the client.

The three outside validators ; a musician, a counsellor and a music therapist, were chosen so as to obtain differing viewpoints and modalities on the improvisations. Each validator was asked to comment in the same way on the assessments with the clients, although they were requested to consider the initiatives of the music they heard from their own professional standpoints, e.g the musician was asked to comment on the musical paradigms, the counsellor on the therapeutic relationship, and the music therapist on the product as a whole. After all the verbal validation had been collected and transcribed it was tabulated in order to find those areas of the highest density of tape stops, and to discover the specific parts of the improvisations that were conclusively chosen by all four people.

Note. All three outside validators did not have access to the scores, and commented on the audio tape only.

3.5. Stages of the Analysis.

The methodological structure, on which the three analyses are based, was formulated from a five stage hierarchical fundamental. Stages one to three investigate the improvisations in terms of the complete therapeutic process through to a micro-analysis of two specific sections from the selected improvisation. Stage four (see Chapter Seven) consists of an evaluation and synthesis derived from stages one to three, and stage five proposes an overall evaluation of the findings from chapters three to six.

Stage One : An Idiosyncratic Description.

A descriptive synopsis of the period of therapeutic intervention including the client's own assessments, the therapist's subjective viewpoint and outside validators' data, where appropriate.

Stage Two : An Integral Investigation.

An inventory of musical interrelations for the complete improvisation, highlighting discernable constructional paradigms.

To select two sections for micro-analysis on the basis of the following criteria :

- those occasions during the improvisation where more than one tape pause was recorded (Client and/or outside validators verbal assesment data)

- those periods where there is an evident density of tape pauses (verbal assessment data)
- those sections, contained within the verbal assessment data, where there is available the richest amount of material
- that the sections chosen for analysis should be extracted from musical parameters of grammatical sense.

Stage Three : A Single Constituent Analysis (for the two selected components).

- Collate and categorize the specific verbal assessment data
- Adopt analytic procedures which will highlight the accounts raised in stages one and two, considering specific questions of therapeutic intent, and musical invention and process
- Investigate specific musical constructions e.g. harmony, melody, rhythm, in an attempt to discover the essential building-blocks of the improvisation. Compare and contrast with the verbal assessment data, and the therapeutic process as a whole.

Stage Four : Evaluation and Synthesis.

- Compare and contrast the findings of levels one to three
- Formulate various conclusive statements of music analysis and therapeutic outcome, for each individual therapeutic improvisation.

Stage Five : Review and Findings. (Part Three. Chapter Seven.)

- Evaluate the results of the hypotheses
- Compare and contrast the therapeutic and musical processes analysed in stages one to four
- Compare the analytic procedures of level three
- Suggest certain musical and therapeutic criteria of individual therapeutic improvisations for people living with the virus HIV and AIDS.
- The significance of this project for further music therapy research.

Part Two.

Chapter Four.

Analysis One. Eddie.

4.1. Stage One. An Idiosyncratic Description.

Dates of Intervention. 9:11:89 - 13:6:91

Number of sessions : 45

n.b All the comments made by the client, have been extracted from the assessment session.

4.1.1. Introduction.

Eddie referred himself for music therapy, whilst being employed at London Lighthouse. Eddie was diagnosed as carrying the HIV virus, and was physically well. He appeared to have a positive attitude to his work, and was very keen to discuss with me the possibilities of music therapy.

The assessment session consisted of a verbal discussion lasting approximately thirty minutes. It was agreed after this time, that we would enter into an initial contract of ten sessions. This would then be reviewed and either terminated or extended into longer-term work.

Musically the assessment session focussed on the dynamics of improvisation. Eddie had improvised for many years with friends, their inspiration originating from the improvisation group AMM. AMM began in 1965 with Keith Rowe, Lou Gare, and Eddie Prevost, their aim being to

break down the formal boundaries of Jazz and to formulate a much simpler, freer approach to improvisation (Ansell 1982). Philosophically, their intention was to formulate a completely “free” style of playing, crossing the boundaries of Jazz, and serious music. Stylistically their music avoids tonality and regular meter, in favour of a more atmospheric and aleatoric form of improvisation.

Eddie explained that he had no formal training in music. He did feel however, that he had the ability to attain a competent standard on guitars and keyboard, necessary for himself and the other members of the improvisation group. He expressed his dislike of most western music that took its theoretical base from any set of rules, and found that his own musical inspiration came from a total freedom of artistic expression. Contradictory to this concept of freedom, Eddie had concluded that some of the music expressed through the improvisation group had become of late somewhat detached and cliched and was not providing the musical discharge he required. He saw the chance through music therapy, on a purely musical level, as a time to consolidate his improvisatory competence, whilst being given the space to explore other avenues of musical expression that were not available through the group.

Eddie’s HIV diagnosis in 1987 forced a complete revaluation of his life. He made contact with London Lighthouse in the early stages of its development, and became heavily involved in co-counselling, a form of intervention that takes its core from the concept of two equal co-counsellors, rather than therapist and client (Jackins 1965). He began to work full-time for Lighthouse in the support services department, and became committed to supporting the organisation’s general growth.

Physically and psychologically, Eddie appeared stable. He was however experiencing certain symptoms of the HIV disease, that were causing him some concern. These were a) sleeplessness, b) weight loss and c) a small amount of diarrhoea. Whilst Eddie realised the inevitability of these manifestations, he did find it difficult to articulate his feelings with regard to physical deterioration and the possible effects on his psychological state. He hoped that through a non-verbal medium it would be possible to address some of these specific issues he faced in living with the virus.

Whilst Eddie had found co-counselling to be a highly effective medium in which to address his own personal issues, he did recognise its limitations. The inherent lack of boundaries within this approach, and the continual shifting of the supporter and the supported, had caused him some concern. He was eager therefore to have the roles of our potential relationship clearly defined so that he could gauge our individual roles before the work began. Through an exploration of possible therapeutic pathways, it was agreed that we would set our boundaries from the defined roles of therapist and client, and that any future developments would be taken from that primary base.

The final part of the assessment session focussed on the possible ways that we might incorporate both music and therapy, into an integrated dynamic approach necessary for Eddie's needs. Eddie wished to view the sessions on four possible levels: a) as music, b) as therapy, c) as music therapy, and d) as words. He explained that he saw them as independent and yet affiliated to each other, and expressed the desire for either therapist or client to be able to focus on any constituent independently, collectively, or in varying combinations.

4.1.2. Description of the Therapeutic Process.

4.1.2.1. Sessions One to Ten.

The first ten sessions were exploratory. It was agreed that no decision would be made with regard to ongoing work until session ten. Most sessions would include three to four improvisations, lasting between ten and fifteen minutes each. Eddie was keen to explore as many different sounds as possible. He would experiment extensively with each instrument, and favoured a non-conformist technique of playing. For the most part the improvisations were not confined to any particular instrument or musical format. On untuned percussion he would rarely play within a regular pulse, and on tuned percussion (including guitar and piano), his melodic and harmonic content was aleatoric, and atonal. He rarely allowed silences, and his style of expression was intense and chaotic.

Verbal avenues of expression were limited to discussions with regard to the musical content, very little mention being made about his own personal state. Eddie talked with great fervour about his love of improvising, and would relate the direct experiences of the music during the sessions to those encountered within the improvisation group.

The developing relationship between therapist and client was initially discussed from a musical perspective. He expressed his frustration with my musical role as therapist, in that he felt that I was constantly trying to mirror and in general terms make something more of his musical expression than he actually desired. He felt that, if our musical relationship was to survive, I as the therapist, must feel

the freedom not only to help him facilitate a directed musical expression but that I must also have the right to make my own musical statements, even if they were contradictory to what he was expressing at the time :

"Surely the music isn't supposed to hold the hand of the client, it's supposed to facilitate the client maybe to do this, that, or the other. It's not necessary to save the world with your music. At this point I felt that is what you were trying to do, and it became a block for me."

The majority of session ten involved a discussion assessing the initial nine sessions, plus his feelings about continuing music therapy. He felt unclear about the relationship between music and therapy. Whilst on one hand, he found the music exciting and invigorating, on the other he was unsure how effective the music therapy process was in addressing the specific issues facing him personally.

"I remember feeling at this point that perhaps like the co-counselling theory, if one's catharsis or discharge, if it's done through an artistic medium, it can become an addiction itself. It can become patterned, and therefore it does work as a way of letting off steam, keeping us alive, but whether it shifts us in any significant direction, I wasn't sure. Maybe I was expecting too much, but if I was to continue with music therapy, I wanted to feel assured that it was going to give me more than just an emotional discharge. "

The theory of possible therapeutic direction discussed in the assessment session, had in practise become less clear and more complex. After discussing his doubts with regard to the efficacy of music therapy for him personally, he expressed a desire to continue for

another ten sessions. It was agreed that we would formulate certain aims during this session that might clarify and consolidate the future direction of the work :

1) To evaluate direct links between the musical experience and the therapeutic direction.

In order to facilitate this the following criteria would be set :

a) that after each improvisation we would sit in a separate area of the room, facing each other, for a limited amount of time

b) that this would be a direct time to reflect, verbally or silently, on the musical experience

c) that either party would have the right to contest or explore each others role within the improvisation, and that complete honesty would be required in any verbal reflections with regard to i) each individuals experience and ii) the music therapy process as a whole.

2) to be clear about the role of improvisation within the sessions, as opposed to that of the improvisation group

3) to refine the use of instrumentation in expressing specific therapeutic and/or musical avenues

4) to consider the role of the piano as an equal member of the percussion group and not, due to its size (a grand piano), as being in any way elitist or special

5) to consider Eddie's HIV diagnosis, not as a separate issue, but as an integral part of the music therapy process

6) that we would not discuss issues of death and dying, unless it was completely unavoidable (Eddie felt that he was not yet ready to face these issues directly).

4.1.2.2. Sessions Eleven to Thirty.

The problems encountered during the first ten sessions came to a satisfactory conclusion within this next stage. The aims formulated in session ten served to highlight the need for more specific boundaries. These having been established, a clear direction evolved which was more pertinently applicable to the music therapy relationship. Both the roles of therapist and client became secure, enabling a freedom of musical expression that was clearly within the bounds of music therapy. By session fifteen, Eddie expressed his wish to make the sessions ongoing, and not confined to ten-week blocks.

Sessions eleven to twenty were concerned with developing an improvisational schema. This period was to prove crucial :

"I wanted during this period to refine our improvisations so that I could feel happy about what I could expect to happen during the session. I was beginning to feel much more exposed both musically and personally, and so needed the safety-net of boundaries, in the sense that I was aware of a method of improvising that would encourage and not stifle what I wanted to express. I became aware that once I began to improvise, that it became a channel to let out all my own stuff, and that can be frightening. I needed to feel safe both musically and therapeutically."

As the sessions developed, so the avenues of music and therapy became less clearly separate, culminating in an integrated balance by session thirty. This occurred gradually :

"I remember thinking in retrospect, how we started out. Thinking of the music, and the therapy, as being quite separate, and the problems that happened because of this. Then, quite unintentionally, they became joined. This is when I really began to find a personal benefit from the sessions. I felt happier about exploring areas that I would have normally held back on, due to the fact that before I felt insecure about the music therapy balance."

Musical schema were developed within this period :

a) Musical freedom - loud, aggressive, and aleatoric in style.

"The periods of wild, free playing, are very important for me, and balance the times when the music is more controlled. It is at these times that I can lose control, be frenzied, and let go of all my inhibitions, be angry, violent even, it doesn't really matter what I do musically. But I don't think on the other hand that we are ever completely chaotic, I don't think we want to be. We accept the chaos within us, but we don't want to be chaotic."

b) Musical specificity - the overall nature of the music would become consonant and would contain the generalised procedure of a theme and variations.

"What I do during these periods, is I find a combination of notes, or chords, that sound right, so I work on them, and worry away at them, and do different permutations of them, and then maybe play them in a different octave, or in another part of the scale. As a non-musician, I'm not necessarily going to

know what I'm playing is going to sound like."

c) Atmospheric material - a combination of broad sparse sounds. (ppp - mp.)

"I'm really into atmospheric music, the whole idea of sound, and space. Atmosphere created by relatively little, and a degree of sensitivity, though not obvious sensitivity."

d) Musical technique - technique as a form of catharsis.

"I'm thinking here of how the energy works within the whole scheme of things. That I'm putting it out, because I'm getting something out of an instrument, which has a lot of noise available in it. That sort of resonance that actually feels the way I do inside, and therefore it comes back into me. And when I hear another sound, so more comes out. So once I've got past a certain technical point in the developing technique, where you actually sustain a finger, or two, it becomes very cathartic and musical at the same time."

Each of these categories would be developed either individually, or superimposed within the overall structure of the improvisation.

4.1.2.3. The University (Research) Session (Twenty-one)

Eddie agreed to be an active participant in the research project. He was concerned that it would represent clearly the balance between musical content and the therapeutic intent. He foresaw problems with regard to the validation of the work, and was enthusiastic to help find an avenue of investigation that would represent his own work both musically and therapeutically, on equal terms. He took a personal

interest in its development, presenting me with problems of methodology as they occurred.

"I often thought about what the arguments of your writing would be. Look out that they aren't going to find sneaky little holes so that they can attack you, because some people aren't going to like what you are saying. They can't actually deny the argument, from the point of view that they know people have souls, and they know people can express themselves. So looking at the music as music and therapy can tell us more about what is going on during the actual improvisations. You're taking music therapy into an area where it's not just psychological, it's also analytical. You can talk to the client about the technicalities of the music, and you can also look at it on your own, and make deductions about what is going on."

The session consisted of three improvisations :

- 1) Percussion and piano.
- 2) Piano four-hands (Eddie, bass. Colin, treble)
- 3) Piano four-hands (Colin, bass. Eddie, treble)

Improvisations one and two consisted mainly of musical freedom, improvisation three being evenly distributed between musical freedom, specificity, atmosphere, and technique. Eddie identified that improvisation three most clearly represented his definitive musical expression at that time and requested that it should be this piece that was taken forward for analysis.

4.1.2.4. Sessions Thirty-One to Thirty-Eight.

Eddie's health began to deteriorate (he resigned from London Lighthouse), he experienced weight- loss, night-sweats and chronic

diarrhoea. Eddie became frightened, angry, and detached. He would become verbally agitated when discussing the improvisations and would transfer to me his negative and destructive feelings. Musically the balance of differing gradients of expression and technique, were abandoned in favour of an almost constant chaotic style of improvisation.

The following revaluation of aims emerged gradually during this period :

- 1) that verbal dialogue would be kept to a minimum, only being incorporated as and when Eddie felt it appropriate
- 2) that the specific areas of frustration and aggression would be targeted as the primary areas of musical and therapeutic development
- 3) that we would not discuss issues of death and dying.
- 4) that the therapist would not attempt to reflect or interpret.

Eddie's feelings of hopelessness and aggression were transferred onto me. His hopes for the future dissolved into a desperate bid for the regaining of his health, and the realisation that this might not happen. His defensiveness and inability to face the reality of the situation were expressed through the improvisations with great accuracy and force. He avoided any verbal expressions, leaving the sessions with feelings of painful questioning.

My reactions to Eddie, in psychotherapeutic terms, were intense and complex. Countertransference has come under much debate in psychoanalytic circles. (Winiarski 1991, Cox 1978). Muskin (1989) recently divided it into two categories :

- 1) The Broad Spectrum - the reaction to the client.

2) The Narrow Spectrum - the therapist's feelings that are idiosyncratic perceptions of the client.

In terms of the "broad spectrum" (Winiarski 1991), I experienced feelings of being "used" as a therapist and as an individual. The lack of respect I felt for myself being the target of Eddie's anger, and the ultimate feeling he transferred to me of being ineffective in my role as therapist, resulted in sessions that were difficult and painful for both parties. My own psychotherapy during this time became essential. In terms of the "narrow spectrum" many questions came to the fore : was I right to let Eddie control the therapeutic direction ? and should I not have been more confrontative ? By agreeing not to discuss issues of death and dying was I avoiding my own fear ? What was Eddie expecting of me ? There were also avenues of over identification : how close had I become to Eddie ? and how difficult was it for me to accept and deal with my own fears with regard to his potential death ?.

Priestly (1980), through analytic music therapy, has categorised thirty-two ego defences. Six of these categories encapsulate clearly the defenses that were manifested :

- 1) Repression : keeping impulses or ideas unconscious
- 2) Denial : disavowing or disowning an unwanted aspect of self, impulse, or experience
- 3) Suppression : willfully inhibiting an unwanted thought or deed
- 4) Phobic Avoiding : staying away from objects or situations which trigger or symbolise anxiety
- 5) Confusion : feeling disorientated and foggy, despite clarification
- 6) Psychic numbing : dulling or blunting of feelings during a trauma.

In terms of therapeutic intervention (Bruscia 1992), there were no clear answers. It became necessary therefore, to trust my own professional instincts. I carefully graded those times of therapeutic confrontation, though ultimately it was impossible to know what reactions would occur, and how these might enhance or damage the therapeutic and musical alliance.

4.1.2.5. Sessions Thirty-Nine to Forty-Five.

Quite unexpectedly Eddie's health improved. He gained weight and began sleeping better. He still suffered from bouts of diarrhoea, but in general terms became physically stronger. The sessions at this point became vital and potent. The following variables for this change must be considered :

- 1) sessions thirty-one to thirty-eight, whilst being difficult in content, had the effect of bonding the music therapy alliance
- 2) Eddie knew that the end of our music therapy relationship was near
- 3) the change in Eddie's physical condition disclosed a strengthening in his psychological state.

All these factors contributed to a complete breakdown of the barriers set up in sessions thirty-one to thirty-eight. The improvisational schema, conceived in sessions eleven to thirty, was resumed and developed. The verbal components of the sessions became focussed and clear, with the concepts of death and dying now incorporated positively within the music therapy framework.

The concluding period of sessions acted as a nucleus of therapeutic intent. This breakthrough could not have occurred without the preceding transitional stages.

4.2. Stage Two. An Integral Investigation.

Player classifications :

Player one - Client = (C) P1

Player two - Therapist = (T) P2

4.2.1. Principal Improvisational Schema.

The Improvisational form is constructed from a set of four basic musical constructs : a) repeated single tones, b) generative cell/motive, c) aleatoric construction, and d) melody and accompaniment. These constructs are contained within three rhythmic classifications : a) rhythmic regularity, b) rhythmic irregularity, and c) rhythmic polymeter. The musical relationship between players is based on a dual process : a) congruent musical invention and b) opposing musical invention. The improvisational schema that develops from these nuclei is based on a musical procedure that incorporates each division both individually and jointly.

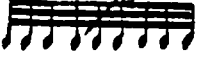
4.2.2. Aspects of Metric Transcription.

In formulating a notational procedure which would accurately represent the differing styles of musical schema, a three-tiered transcriptional form has been adopted. In addition to the re-transcription discussed in chapter three (see 3.2.), an additional transcriptional formula was adopted to represent those passages in the improvisation that were too complex to adhere to the above aural procedure. At these points a literal score transcription became necessary excluding aural influences : a bar of the hard-core data was extended to four times its actual length, (e.g. a semibreve equals a

crotchet), consequently the score conforms to an exact mathematical representation.

Tier One - Metric regularity (aural transcription). A suggested time-signature is notated in brackets. e.g. $\left(\frac{3}{4}\right)$

Tier Two - Metric irregularity (aural transcription). No time signature is incorporated. Dotted lines denote clear divisions of musical structure

c) Metric irregularity - (literal score transcription) (X) denotes those passages where all individual and associated musical ideas are notated without fixed derivations. Inner sub-divisions of free rhythmic groupings are transcribed via a / notational format. e.g. () It is not necessary for one part to correspond to any of the other rhythmic components.

4.2.3. An Inventory of Musical Interrelations.

The Improvisation will be described in terms of the divisions and constructs outlined in 4.2.1. For divisional purposes the improvisation has been randomly divided into four main sections.

Section One. 0:00 - 2:35.

0:00 - (C) P1 begins the improvisation with repeated single notes, (B) (rhythmic irregularity) with an octave leap at the end of each phrase. (T) P2 plays isolated chords

0:40 - (C) P1 develops the musical direction with three rising and falling phrases, interspersed with a recapitulation of the repeated

single tones at 0:49

1:06 - (C) P1 initiates melodic phrases in sevenths, with repeated single notes (D flat) (T) P2

1:31 - a melodic bridge passage in octaves leads to a passage (1:40) of rhythmic regularity based on a cell. (G,A,E,F) (C) P1

1:45 - (T) P2 accompanies with an extended rhythmically irregular fast configuration

1:55 - (C) P1 an improvisational schema is developed initially on B, the opening note of the improvisation. It's core is taken from repeated single tones, which are then developed into more melodically informed phrases. (T) P2's rapid phrasing becomes slower and at 1:59 both players combine towards the same quaver tempo

2:06 - the core note of (C) P1's schema is now based on E, accompanied with a chordal syncopation (T) P2

2:10 - the melodic development (C) P2 is further extended by the rhythmic inclusion of semiquavers

2:17 - (C) P1's schematic core is now based on D, and the musical design is in two parts between both players. (T) P2's tonal centre is based on D flat

2:24 - the improvisation takes the form of a two-part invention leading at 2:33, to a short descending scale bridge passage (C) P1, with syncopated chords (T) P2.

Section Two. 2:35 - 6:30.

2:35 - a bridge passage

2:38 - A motif consisting of loud chords (C) P1/(T) P2, interjected with quiet repeated single notes (B flat, followed by A flat) 2:55

3:03 - rhythmic polymeter, aleatoric construction. The section is short and concise, and is not developed.

3:22 - a return to the repeated single note schema (3:22 -B flat, 3:33 - F sharp) (C) P1

3:35 - a dual invention between players ; (C) P1 develops melodic phrasing into three ascending chromatic scales, whilst (T) P2 initiates a slow moving chorale

3:54 - (C) P1's descending scale is united with (T) P2 by a faster-moving harmonic configuration

4:00 - (T) P2 directs the harmonic centre to B flat minor. (C) P1 responds with an extended phrase of rapidly repeated single tones (E flat) underwhich (T) P2 pivots on two chords

4:16 - (C) P1 develops a lyrical melody with a short tail-phrase of repeated single notes (D) (4:25). (C) P1 accompanies with spread chords. (T) P2 based on E flat

4:31 - 5:44 is an extended passage initially based around two notes (C) P1 (E flat, D), (rhythmic irregularity) interspersed with single chords and a cell of two intervals. (D natural, D flat, and A flat, E natural) (T P2). The cell originates from the opening interval of the improvisation (0:06), and is later developed at 8:18, 9:52 and 12:26.

5:06 - (C) P1 develops a melody (6/8) ($\text{♩} = 42$) in octaves against a sequence of chords (T) P2 remaining in an unrestricted tempo.

5:44 - (C) P1 initiates an accelerando of repeated intervals (minor 7th), which at 5:53 returns to the original tempo.

6:00 - the music continues in the duality of musical invention between players. (C) P1 continues with a melodic development, moving into a series of accented descending chromatic phrases. This is offset by (T) P2 who continues with simple chords and two-part melodic phrases in contrary motion to (C) P1.

Section Three. 6:30 – 11:41.

6:30 – 6:43 comprises a section of aleatoric construction and rhythmic polymeter

6:43 – 7:05 (rhythmic irregularity) – both players explore the repeated single note schema based on D flat, alongside musical ideas related to 6:30 – 6:43.

7:05 – 8:18 is a more fully developed section of aleatoric construction and rhythmic polymeter. Initially (7:05 – 7:11) the musical construction is free

7:11 – 7:28 the direction is directed towards two core semitonal intervals on which this section of the improvisation is based : (C) P1 A natural/B flat, (T) P2 E flat/D natural.

7:28 – for a brief instance the musical flow becomes dissected, converging into a passage of lyrical aleatoricism (7:32 – 8:07)

7:50 – (T) P2 partially recapitulates the slow moving chorale improvised at 3:35. This grounds the ethereal textural playing of (C) P1

8:07 – 8:18 consists of a short bridge passage of rhythmic regularity (

8:18 – 8:49 – (C) P1 develops a melodic cell (D flat, C, B) originating from a repeated single note schema (D flat). This is underpinned by syncopated chords (T) P2 originating from the two intervals highlighted at 4:31.

8:41 – (C) P1 evolves the cell into three descending scales, the second and third of which (T) P2 align in contrary motion

8:49 – 9:07 the musical material remains constant, the rhythm now becoming polymetric and syncopated with extended trills (T) P2

9:07 – 9:26 is the first of two sections concluded with a bridge passage. It comprises randomly placed intervals between both players.

9:26 – 9:38 the second section becomes more forceful with an accelerando and crescendo, based on repeated single chords

9:38 - 9:48 a short bridge passage (C) P1 dissolves the texture into the next section of the improvisation.

9:52 - 10:46 a self-contained thematic passage (rhythmic irregularity) the fundamental of which originates from a cell of four notes (B flat, B natural, F sharp, F natural) (C) P1. (T) P2 accompanies with an improvisational schema similar to that of 4:31 : single chords interspersed with repeated intervals (see 4:31)

10:46 - 10:58 fast tempo leading to a development resembling 7:11

11:18 - (T) P2 continues the preceeding invention, whilst (C) P1 introduces a core-cell as a basis for invention (A natural, a flat, G, G flat and F)

11:22 - (T) P2 dissects the development of the core-cell with detached chords, at 11:26 with sustained bass octaves (D flat) and at 11:34 with major seconds (D flat, E flat)

11:36 - (C) P1 the core cell is abandoned, becoming slower in tempo melodically descending to E flat. (11:41)

Section Four. 11:41 - 14:15.

11:41 - 13:36 (rhythmic regularity/rhythmic irregularity) an extended lyrical passage. (C) P1 improvises within the pentatonic mode based on D flat whilst (T) P2 fluctuates between a D flat tonal centre (11:46) and C natural tonal centre (12:39). (C) P1 initiates the opening of this section with repeated single notes (E flat). At 11:56 he extends this idea into a melodic invention. The melodic improvisational schema forms the basis for (C) P1. (T) P2 accompanies with isolated chords, at certain points recapitulating the two intervals initially stated at 4:43.

12:39 - (T) P2 introduces a chord sequence diametrically opposed to the pentatonic playing of (C) P1

13:36 - 13:50 can be viewed as a bridge passage leading to the coda proper at 13:50.

13:50 - 14:15 (rhythmic polymeter-coda) recapitulates the fast sections of the improvisation. (C) P1 incorporates an extended trill (A flat/G flat) (T) P2 utilising random pitches interspersed with short stabbing octave phrases. (D flat/D natural) From 14:03 (T) P2 initiates added chordal syncopation which brings the improvisation to a close with a unified staccato chord.

4.3. Stage Three. Two Constituent Analyses.

Analysis one : 7:05 - 8:18

Analysis two : 11:41 - 13:46

4.3.1. Analysis One.

Chronologically, analysis one lies mid-point within the improvisation. Structurally, it is the first of two aleatoric construction/rhythmic polymeter periods. The musical freedom of these passages, harmonically, rhythmically, melodically, and texturally, lies in stark contrast to the rest of the musical material. The musical disposition is tense and taut, displaying an intensity of feeling contained within an aleatoric framework.

For the purposes of this analysis the passage has been divided into six sections, which form the sub-classifications of musical invention. The subsequent inner divisions have been utilised for analytic purposes only.

- 1) 7:05 - 7:11
- 2) 7:11 - 7:28
- 3) 7:28 - 7:32
- 4) 7:32 - 7:50
- 5) 7:50 - 8:07
- 6) 8:07 - 8:18

4.3.1.1. Observational Data.

The client, and the three validators, comment on this passage from differing perspectives :

"The music feels like I did at that time - frustrated. I didn't care, I felt hostile and angry. I wanted to express this by using the piano like a percussion instrument. I wanted to make splodges of sound, and lose any sense of trying to get things right or make good music. The thing that surprises me listening back now, is how technically good it sounds, because at the time it felt shapeless. I wonder what this says about expressing aggressive feelings through music ?. I would be really interested to see how much shape and patterning there is in this section. " (Eddie)

"This improvisation seems to survive on outer and inner levels, and I feel that this section lies very much on the inner level. The music begins atonally with displaced tones. This is followed by a section centred on a trill in the middle register (E flat, D). The treble explores motifs based around A and B flat, the bass providing a solid root both tonally and rhythmically. This music reminds me strongly of Messiaen : the treble playing in unstructured clusters with a rooted chorale-like bass. In purely musical terms I hear an overall predominance of D flat in the bass. From an aesthetic viewpoint the

questions that are raised for me here are to do with a style of musical expression that is so free and yet in formal terms beautifully textured and formed. The tense feeling of the music is balanced within an overall structure of intense beauty.” (Musician)

“This feels like he is running scared, confusion, and panic. It has got focus though, it’s not just chaotic. It has got an animal-like quality for me, but it is centred. I also think that you are giving him a solid grounding in the bass. Rather than you being in a supportive role, and being a listener, here it feels that you are giving him support in a much more secure way.” (Music Therapist)

“I felt that there was a lot going on in that section. There was a sense of the top register trying to reclaim a sense of attachment and belonging, and the bottom register feeling quite isolated from what was going on. I felt that the top register wanted to recover the closeness and intimacy that had been explored and experienced in the section before. And maybe that’s why the introductory material came back (7:50), a sense of really needing to re-discover that. But I don’t think that could have occurred because of what the two people had shared in the first half of the improvisation. Things have changed, progressed, I feel a sense of searching.” (Counsellor)

4.3.1.2. Intervallic and Harmonic Consequences.

The overall structural harmonic design (see Figure Five) clarifies what appears to be, from the full-score, a random combination of tones and chords. By further reducing the harmonic foundation provided by the bass (T) P2, a D flat fundamental is discovered. Contained within this suggested tonic core, there is at 5b the implication of a further integrated harmonic nucleus : E flat.

SECTIONAL DIVISIONS.

7:05

8ve-1

7:06

(G) P1

(T) P2

P.L.

7:11

7:15

7:22

7:28

7:32

7:50

7:55

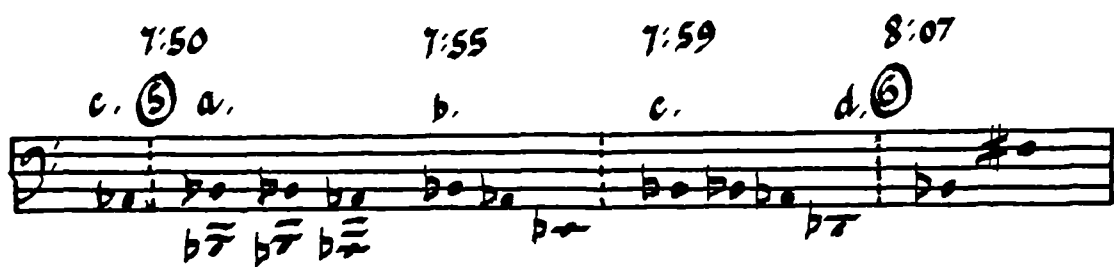
7:59

8:07

8:11

The musical score is written on two staves, (G) P1 and (T) P2. It features various musical notations including notes, rests, and dynamic markings. The score is divided into sections by time stamps: 7:05, 7:06, 7:11, 7:15, 7:22, 7:28, 7:32, 7:50, 7:55, 7:59, 8:07, and 8:11. There are circled notes and dashed lines indicating connections between them. The notation includes notes with stems, beams, and various accidentals. The score is labeled with 'SECTIONAL DIVISIONS.' at the top left and 'P.L.' at the bottom left of the first system.


Figure Five.




By examining Figure Six, it is possible to categorise four basic note groupings that form the nucleus of the combined improvisational tonal direction:

- 1) The intervals of a fifth and a sixth.
- 2) The interval of a second.
- 3) F sharp, A flat, and D flat.
- 4) F sharp and B flat.

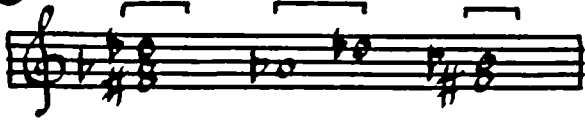
① 7:22



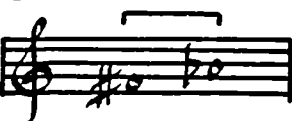
② 7:28



③ 7:32 7:28 7:15




⑤ 7:22/7:32

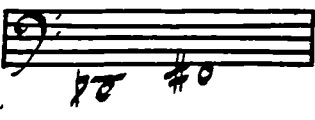


(C) P. 1.
(T) P. 2.

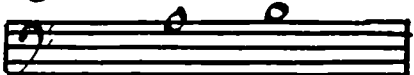
② 7:11



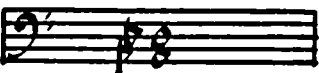
③ 7:28



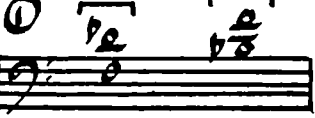
②



③



① 7:55



note: Identification of intervals in the full-score are taken to the nearest time-division.

Figure Six.

Groupings three and four are the most structurally pivotal containing the greatest number of occurrences. This intervallic set relationship is identified on the condensed harmonic score. (see Figure Five) Category 3 = 0, and category 4 = +.

These groupings demonstrate the importance of certain essential core intervals and chords. The predominant note grouping +, is initiated by player one (1a), the D flat being immediately utilised by player two (1b) to suggest a harmonic base. The harmonic and intervallic relationship becomes increasingly more complex, culminating at sectional division three (see Figure Five) where the combination of tones in grouping three are used by both players. The Interval set 0, whilst being of less harmonic structural importance than +, does provide a balance of invention, which is first stated by player one at sectional division 2b, and then incorporated more significantly at 2f. By 4c both sets are combined, and at 5d there is a unified integration of notes within a single chord.

Whilst it is not the intention of this section to attempt a generalised extrapolation of interval groupings and therapeutic validity (similar to those basic assumptions explored by Deryck Cooke), it could be suggested that in this improvisation, for this client, there is a direct link between certain critical intervals and the therapeutic process. This assumption whilst being unproven in concept, is expressed as a possibility rather than as a conclusive actuality.

Note. Cooke (1959) attempts to establish the view that there is a specific melodic vocabulary of emotions (Small 1984).

4.3.1.3. Rhythmic Consequences.

During this passage, it is difficult to perceive any regular meter. At 7:50 the introduction of a more regular pulse (T) P2, is also contained within a fluctuating metric framework. n.b. Similar notational groupings between players do not necessitate a linear aural alignment.

It is possible to analyse this section rhythmically in terms of a) essential segmentation (pure rhythmic groupings as they appear on the score) (see Figure Seven), and b) phrase relationship segmentation (groupings in terms of the musical and therapeutic relationship). (see Figure Nine)

The intricacies determined from this perspective in terms of the essential segmentation, are highlighted, by the musician :

**“Rhythmically the meter is irregular and displaced.
There is a fluidity of pulse which forces a
complexity of rhythmic content.” (Musician)**

In the essential segmentation (see Figure Eight), there is a predominance of three-note groupings (players one and two) This is counterbalanced by a five-note segmentation of secondary importance (player two), contrasting with the structural significance of the continuous lengthened free flowing phrases (see classification group 11). Odd numbered groupings as opposed to even (26 >18), take precedence, contributing to the ametricity of the rhythmic structure.

(G) P1 7:05 7:06 8:07 8:07 8:11

① ② 3a 3b 3c 4a 4b 16 17 19 20

CONCISE RHYTHMIC PHRASES

T:11 7:28 7:32

⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫

EXTENDED RHYTHMIC PHRASES

7:50

⑬ ⑭ ⑮

MELODIC RHYTHMIC PHRASES

Figure Eight.

The improvisatory therapeutic relationship when classified via phrase structure, (phrase relationship segmentation. see Figure Nine) can be illuminated further by considering the comments of the client, the music therapist, and the counsellor.

"The stabbing rhythm (7:28) is like chords that a piano would often do in jazz with drums and saxophone. Pushing at something while maybe the soloist is going over the top playing lines. This whole passage is unsettling because we are playing anything, but on the pulse. Because there isn't a walking bass line it sounds very syncopated. I remember feeling that I didn't want anything to be stable at this point, I didn't want there to be anything to hold onto. This ties in with my feelings of frustration and of feeling lost." (Eddie)

"This syncopational and free episode which is now developed more, is in a sense consolidating what happened before in the improvisation. The lack of anything to hold onto rhythmically is very telling and the rhythmic relationship between both players appears to be significant. This feeling of being at sea, whilst on one hand is very unsettling, on the other hand is extremely liberating." (Counsellor)

"This section is difficult to interpret because of the inconsistency of rhythmic base. I feel as though something crucial is being said through this avoidance of regular pulse. You punctuate what he is doing firstly with clipped chords (7:28), and then with a slow solid pulse (7:50). This is really strong and earthy and in a sense it gives him the permission to be all over the place on the top, because he knew you were holding him safe." (Music Therapist)

The phrase relationship segmentation is divided into twenty sub-classifications, which are then grouped into three broad headings of concise (rhythmic phrases that are short in length), extended (rhythmic phrases that are extended in length), and melodic rhythmic phrases (rhythmic phrases based on a melodic line). The concise groupings are a self-contained nucleus of expression. They are rapid and irregular in content. The extended rhythmic phrases are more secure in terms of relationship and structure, balancing and providing continuity to the surrounding rhythmic ametricality. The melodic rhythmic phrase (player two) is an organic extension of the previous heading, providing contrast and grounding to the rhythmic development. It is slower in terms of general meter and therapeutically was critical (see music therapist's comments) in supporting the free expression of player one.

4.3.1.4. Textural Considerations.

The textural considerations of this passage contain basic primary elements necessary for the clarification of the overall structural components. The basic interaction of musical strands that go to make up this sectional analysis, can be classed as monophonic (a single sounding part), homophonic (a primary part with accompaniment) and polyphonic (several parts of relatively equal importance sounding together) (Lester 1989). These musical terms can be further adapted in relation to the therapeutic relationship :

monophonic - the sounding of the therapeutic relationship as one unit.

polyphonic - the equality of differing therapeutic directions sounding together.

homophonic - a primary importance therapeutic strand, accompanied by another player.

These classifications will be cross-referenced in varying combinations, in order to extract a unified textural analysis of therapeutic and musical intent. Rather than analysing the whole of this passage texturally, two small components will be selected that are indicative of the section being discussed. .

By analysing 7:06-7:11 in terms of its skeleton register, it is possible to see extreme shifts of pitch in both parts.

The image displays a handwritten musical score for two parts, labeled (C)P1 and (C)P2. The score is organized into three systems, each consisting of a treble staff and a bass staff. The notation is handwritten and includes various musical symbols such as notes, rests, and accidentals. Brackets with numbers 5, 6, and 9 are placed above the staves, indicating specific intervals or measures. The notation is somewhat sketchy, with some notes and accidentals appearing to be corrections or additions. The overall impression is that of a working draft or a sketch for a musical composition.

It is proposed that this pointillistic improvisational schema is monophonic in design. This sudden shift in the texture of the improvisation monophonically can be speculated on both musically and therapeutically : what effects might this passage have had on the therapeutic direction ?, and how important are the musical subtleties of these complex sets of registers in illuminating the possible therapeutic direction and meaning ?. The music therapist proposes a possible link between the change in musical texture and therapeutic outcome :

"These sections, of what appear to be complete random musical invention, must have significance in relation to the therapeutic outcome. Both players are expressing in a unified random texture, which would imply to me, as a music therapist, that more difficult therapeutic areas are being explored, and that this style of playing is crucial in accessing these intense feelings." (Music Therapist)

7:50 - 8:07, provides an example of layered texture which can be classed as either polyphonic or homophonic. These two possible classifications are again discussed by the music therapist :

"I feel that this small section of the improvisation, therapeutically and musically is very important. Player one is making splodges of sound whilst player two is balancing this with hymn-like phrases. This form of playing can be seen either as both players experiencing a unity through opposing musical invention, or as player one accompanying the hymn-like phrases of player two. There are aspects of individualism contained within an overall unity which is musically very beautiful." (Music Therapist)

The clusters improvised by player one whilst being random in harmonic and tonal content, texturally are finely graded, set within specific tonal boundaries (see 4.3.1.2.) and specifically phrased to mirror player two's linear chordal progressions. Through aural and notational analysis it is suggested that the overall texture is that of refined musical invention.

4.3.2. Analysis Two.

Analysis two consists of an extended slow development, prior to what is classed in the informal description (see 4.2.3.) as the coda. (13:50-14:15). This passage contains the longest period of extended musical development, and is the most tonally centred section of the improvisation.

For the purposes of this analysis, this extract will be subdivided into the following sectional divisions :

- 1) 11:41 - 12:26
- 2) 12:26 - 12:39
- 3) 12:39 - 13:00
- 4) 13:00 - 13:05
- 5) 13:05 - 13:20
- 6) 13:20 - 13:28
- 7) 13:28 - 13:36
- 8) 13:36 - 13:46

4.3.2.1. Observational Data.

"This section is beautiful. I really felt as though we were sharing the most intimate feelings, but at the same time doing that very sensitively. We held onto it for a longer period, and it felt right. It expressed the other side of my emotional coin. On one hand I felt angry and annoyed. They were my first thoughts. This section made me realise that secondary to that, but just as important, I had feelings of intimacy and pain, which we expressed through a simpler style of playing. I feel as though the rest of the improvisation was leading to this point. It works because of what has gone before."(Eddie)

"This part of the improvisation is carefully graded and executed. The bass assumes an accompanying role to the treble's melodic inventions in the pentatonic. Both players respond musically in the duality of tonal centres (C natural and D flat), in the freedom of melodic invention and in the fluidity of rhythmic direction and phrasing. What transpires is a section of finely graded musical structure: an extended melodic invention balanced with a carefully placed harmonic base. There are also references to previous material improvised by the bass (12:26 and 13:20). This acts as a catalyst in holding this section musically within the bounds of the whole. This is artistically satisfying but at no time are the musical phrases predictable. The two parts are so integrated with each other, that I can hardly believe this is an improvisation." (Musician)

"The bottom register is still holding the top, it doesn't feel so isolated and separate. Its very much a part of the whole relationship, and for me that's to do with the space that has been developed." (Counsellor)

"This passage is very effective. The treble is playing with a simplicity that is striking, it is saying so much. The musical phrase endings are perfect, there is real listening, both players are there all the time. The simplicity expresses another side of expression and the relationship contained therein. Whatever is being shared comes across to me as being acutely intense." (Music Therapist)

The above comments would seem to suggest that the passage falls into the category; Elements of Communication. (see 1.5.2.) The above observations indicate that this section translated a clear expression to the client and outside validators, which was open to less discrepancies than in analysis one.

4.3.2.2. Harmony.

The harmonic content contains the basis of musical expression. Through basic aural and score investigation, a duality of key centres can be found. Player one improvises within the pentatonic scale harmonically suggested around D flat major. Player two conversely is harmonically focussed around C major. This basic semitonal differential of key centres produces a harmonic fusion of bitonality.

"A lot of this improvisation is atonal, which in a sense makes this even more tonal in feel. I'm playing a pentatonic scale and you are playing something that isn't strictly in tune with that, and yet it's in a complementary key, which when put together with my part produced breathtaking harmonies." (Eddie)

"I find it quite difficult not to reflect on the harmonic content of this passage because I think the general harmony, and the chordal relationships within that, are very much to do with a sense of trust which is now implicit in the chordal structure and therapeutic relationship. I hear two independent keys, and yet what comes across is total integration." (Counsellor)

"Technically the treble is in the pentatonic. The bass initially improvises unrelated chords based around D flat, further responding with step-wise chords originating from a C major displaced tonic (12:39) . This produces a bitonality which is technically dissonant but which aurally produces consonance. " (Musician)

"The combination of different keys, and harmonic ground, I feel is a vital part of the music therapy at this point. Both parts are separate, and yet the combination of both provides a unity which is both subtle and beautiful." (Music Therapist)

It is significant that both the client and the outside validators, considered the juxtaposition of key centres to be pivotal within the improvisation. Whilst there was an awareness of the elements of possible atonality, everyone felt a strong communication of harmonic unity. From a subjective viewpoint, as the therapist, it is important to consider the reasons for the choice of key centre. The decision to counterbalance the pentatonic / D flat major harmony was conscious. Therapeutically and musically I felt that my role was to be alongside, and not directly with, the client's musical expression. The C major base was therefore used to facilitate a foundation that was both complementary, and yet opposed to the creativity of the client.

Handwritten musical score for guitar, featuring chords and time signatures. The score is organized into systems, with measures numbered 1 through 8.

System 1:

- Measures 1-2: (C)P1, 11:41, 11:46. Chords: Dbmaj, Ebmaj, Fbmaj.
- Measures 3-4: 12:01, 12:06, 12:16. Chords: Ebmaj, Fbmaj, Gbmaj.
- Measures 5-6: 12:20, 12:24. Chords: Abmaj, Bbmaj.

System 2:

- Measures 7-8: 12:39, 12:44, 12:47, 12:52, 12:58. Chords: Cmaj, Dmaj, E, F, G, A, B, C.

System 3:

- Measures 9-10: 13:00, 13:05, 13:10, 13:12. Chords: Cmaj, Dmaj, E, F, G, A, B, C.

System 4:

- Measures 11-12: 13:16, 13:20, 13:25. Chords: Cmaj, Dmaj, E, F, G, A, B, C.

System 5:

- Measures 13-14: 13:28, 13:33, 13:34, 13:35, 13:36, 13:40. Chords: Cmaj, Dmaj, E, F, G, A, B, C.

System 6:

- Measures 15-16: 13:36, 13:40. Chords: Cmaj, Dmaj, E, F, G, A, B, C.

Figure Nine.

By considering a harmonic condensation (see Figure nine), it is possible to investigate the duality of parts in more depth. The fundamental harmonic basis for both players, in sectional divisions one and two, is D flat major. Contained within these sections is the unwillingness (apart from chords iv, and v) to adhere to the notes of a tonal chord. What transpires is the basis of a loose D flat major tonal centre, incorporated within an atonal framework :

(C) P1
(T) P2

11:46

The musical notation consists of two staves. The first staff is labeled (C) P1 and the second staff is labeled (T) P2. Above the first staff, there are circled numbers 1, 2, and 3. Above the second staff, there are circled numbers 4, 5, 6, and 7. The notation includes various musical symbols such as notes, rests, and accidentals. Arrows and brackets are used to indicate harmonic relationships and groupings between notes in both parts.

Sub-section three initiates the first statement of the binary harmonic expression. (T) P2 improvises a series of ascending displaced tonic triads (C major, D major, E major) against (C) P1's pentatonic inventions. At sub-section four a further musical idea is introduced within the texture (T) P2, a series of similar motion thirds. Sub-sections six to eight pivot between the D flat and C major tonal centres, the component as a whole ends on a C / D flat duality.

In terms of harmonic understanding of this passage and its possible effects on the music therapy process, it is pertinent to raise questions from both sets of data and their analyses, jointly. That the client and validators felt this passage, in terms of harmonic content, to be salient and thus worthy of further investigation is evident. How important, however, are the intricate harmonic components in providing a base for musical and therapeutic development ? Could the music therapy outcome have been achieved through simpler musical means, and what does this analysis provide in terms of a greater understanding of the harmonic components contained within therapeutic improvisation ?

The main emphasis of this harmonic analysis is based on the concept of antithetical musical expression between players (see 7.3.). In terms of the music therapy relationship, the harmonic analysis serves to clarify the need for the therapist to afford the client the ability to express without the necessity of similar, or combined musical expression.

**"The power in this music lies in the fact that you did not play in the same key or mode as I did. I felt that you were with me but that you did not overcrowd my musical and therapeutic expression. The beneficial outcome for me came through a togetherness that was also intrinsically separate."
(Eddie)**

4.3.2.3. Melody

The melodic direction of this passage is developed by (C) P1 :

"When I play in the pentatonic, it's normally because I know more or less how it is going to sound. It meant that I could improvise a melody freely because the tones themselves were in a set formula. At this point I needed this security, in order to express myself through the tune." (Eddie)

Before considering player one's melodic invention independently, the fundamental melodic relationship (see Figure Ten) needs to be addressed. The analysis contains the outer core melodic configurations of both players. The melodic disposition between both outer parts contains, in the main, contrary relationship phrases. There is a balancing of the basic melodic components both individually and jointly, producing a logical melodic schema. The inner melodic lines, incorporated by both players are an integral part of the overall melodic design also. ((T) P2 ; 13:00, 13:05. (C) P1/(T) P2 ; 13:28, 13:33, 13:38)

By considering the sectional divisions two to four, of player one's concentrated melodic content, it is possible to analyse the contained melodic contours and shape. There is a general tendency towards falling phrases, which rise at mid-point and fall again towards the end , counterbalanced by phrases that rotate around a pivotal axis tone. This investigation demonstrates the consonance of melodic contrast and form contained within the client's improvised structure. The variables contained within such musically sensitive and formal boundaries are concerned with a) the client's abilities as an untrained musician, and b) the therapeutic development that has been reached at this point.

SECTIONAL DIVISIONS

(C) P1

(T) P2

11:46 11:56 12:01 12:06 12:16

12:20 12:26 12:39 12:47

12:58 13:00 13:05 13:10

13:20 13:28 13:33

13:38 13:42 13:46 13:40

The musical score is divided into eight sections, each marked with a circled number. Section 1 starts at 11:46 and ends at 12:16. Section 2 starts at 12:20 and ends at 12:47. Section 3 starts at 12:58 and ends at 13:10. Section 4 starts at 13:20 and ends at 13:33. Section 5 starts at 13:38 and ends at 13:40. Section 6 starts at 13:42 and ends at 13:46. Section 7 starts at 13:48 and ends at 13:50. Section 8 starts at 13:52 and ends at 13:54. The score includes various musical notations such as notes, rests, and dynamic markings like *p* and *pp*. There are also some handwritten annotations like "8ve--" and "8ve-".

Figure Ten.

4.3.2.3.1. Melodic Rhythm.

Two groups of sub-sections will be analysed (sectional divisions 4-6 and 7-8.) in order to extract the essential ingredients of two differing forms of melodic rhythmic fluidity. Melodic rhythmic and tempo fluidity constitutes a major component of the slower tempo sections of the improvisation. The overall design of these constituents normally consists of a single-line or repeated-note configuration (C) P1, alongside slow pre-determined chords (T) P2.

Free Melodic Rhythmic Fluidity. (sectional divisions 4 - 6)

13:00

Handwritten musical notation for 'Free Melodic Rhythmic Fluidity' (sectional divisions 4-6). The notation is spread across three systems. The first system shows a melody (C) P1 and a chordal accompaniment (T) P2. The second system shows a melody with triplets and a chordal accompaniment. The third system shows a melody with a triplet and a chordal accompaniment. Time markers 13:05, 13:10, and 13:20 are indicated above the notation.

The rhythmic transcription of this section is contained within free notational parameters, that is, no one group of notes is a) required to total any adjacent aligned aggregates or b) necessarily regular when written in equal phrase combinations. The rhythmic bias of a and b is induced by player two, the quaver pulse of player one decorating and punctuating the overall structure. From c to f the rhythmic direction is developed by player one, with a slow static rhythmic accompaniment freely incorporated, and rarely coinciding with player two's phrases. B, c, and f, highlight a rhythmic melodic motive, that is utilised to promote a feeling of fluidity ; triplets interspersed with two and four note groupings.

Melodic Rhythmic Fluidity. within Suggested Tempo Boundaries. (Sectional divisions 7 - 8.)

The image displays three staves of musical notation, each representing a different sectional division. The notation includes various note values, rests, and groupings, with specific tempo and phrasing markings.

- Staff 1:** Labeled with $(\text{♩} = 138)$ and $13:28$. It features a treble clef and a key signature of one flat. The notation includes a series of eighth notes, a triplet of eighth notes marked with a circled 4, and a quarter note. A circled 6 is also present. The staff ends with a double bar line.
- Staff 2:** Labeled with $13:38$. It features a treble clef and a key signature of one flat. The notation includes a series of eighth notes, a triplet of eighth notes marked with a circled 4, and a quarter note. A circled 5 is also present. The staff ends with a double bar line.
- Staff 3:** Labeled with $13:36$. It features a treble clef and a key signature of one flat. The notation includes a series of eighth notes, a triplet of eighth notes marked with a circled 4, and a quarter note. A circled 4 is also present. The staff ends with a double bar line.

It is possible, from the above analysis to propose time signatures that will help classify the rhythmic groupings. Sectional divisions 7-8 are developed rhythmically (C) P1 with a free static accompaniment (T) P2, rarely coinciding. (13:33, 13:38) The five rhythmic sets (a-e), can be classified into similar rhythmic groupings :



The upbeats of each phrase are balanced by either a triplet configuration, or in the case of E, an extended group of quavers. The combination of triplets and two and four note groupings, as in the previous analysis, is essential in communicating the feeling of fluidity. The suggested time signature ($\frac{4}{4}$), provides a framework from which to consider the groupings and their importance in moulding the rhythmic direction.

4.4. Stage Four. Evaluation and Synthesis.

The sectional analyses of this chapter demonstrate two contrasting forms of musical and therapeutic expression. In terms of the core content of each section and their possible relationship, it is possible to view each as a multi-layered therapeutic and musical procedure. In analysis one, the components identified for investigation dealt with the possible underlying aspect of intervals, harmony, rhythm and texture, whilst analysis two concentrated on harmony, melody and melodic rhythm. These differentials in the chosen analytic direction on a purely musical level were taken from the music as it presented itself. From a music therapy perspective the choice of component analyses were taken from the points raised from the observational data, plus the desire to look beneath the surface at those elements that directly affected the therapeutic outcome. Eddie, during the period of therapeutic intervention, improvised in two distinct styles both of which were crucial for his development in music therapy. These differing aspects of his musical persona are represented through the two sectional analyses. The combination of each form of questioning resulted in an analytic formula designed to investigate the micro aspects of each chosen section. The evaluative results of these criteria discussed produce information that is relevant to both the stage that Eddie had reached within the therapeutic process, plus the more global aspects of therapeutic improvisation.

Eddie had now refined his therapeutic improvisational language. His quiet and more introvert style of playing (analysis two) always came as a direct result of a more chaotic form of expression (analysis one). The first would normally be contained within more tonal parameters, whilst the second was nearly always in an atonal and aleatoric

framework. The complexities highlighted through both of the analyses, show a greater similarity of musical and therapeutic design, than disparity (see observational data). The outer intricate musical design of analysis one overshadows a simplicity of therapeutic and musical process. Analysis two, on the other hand, is more direct in formulation containing less complex core components.

In analysis one the observational data highlighted the connection between feelings of aggression and searching, and the musical content of pointillism and atonality. The psychological consequences of this form of disclosure provided a strengthening of resolve and acceptance for Eddie, in facing the direct issues of his illness. The ability to explore issues of death and dying varies with the individual (Anderson 1992). Eddie found the verbal articulation around these issues difficult for most of our therapeutic journey (see 4.1.2.1. and 4.1.2.4.). The fear and denial of death and dying is a universal topic at some stage within the psychotherapy process (Becker 1973), and can be seen to be a natural progression for people living with HIV and AIDS. The improvisation analysed falls within this developmental stage, the consequences of which are briefly discussed:

**"The anger that I feel, which is portrayed musically in a mainly disjointed fashion, is to do with my own fears of the illness and the possible repercussions for me. I can express my fears through the music without actually having to spell them out verbally."
(Eddie)**

The combined evaluation of these findings produce results that relate to the importance of unstructured playing, in both a simple and complex format.

The outcome of the improvisational constructions of this chapter in terms of music therapy generally must be approached with caution. The above evaluations should not be regarded as fixed in terms of the musical and/or therapeutic processes. That the two analyses demonstrate differing aspects of a client's disclosure in therapeutic improvisation, suggests a duality of musical and therapeutic expression on both the "outer" and "inner" levels. Psychologically these levels are crucial in attaining a balance between therapeutic intent and musical outcome.

The musical content of therapeutic improvisation was critical for Eddie in discovering an expression necessary for his therapeutic growth. The relationship formulated through the musical parameters dealt with aspects situated on both musical and therapeutic levels: that the representation should be of two equal and independent voices and not of the supporter and the supporting. From a purely musical viewpoint, the two analyses demonstrate the importance of utilising aspects of melodic and harmonic atonality and tonality within the same improvisational framework, and the potential effects both of these forms of expression have upon the client's musical and therapeutic development.

Chapter Five.

Analysis Two. Charles.

5.1. Stage One. An Idiosyncratic Description.

Dates of intervention: 19.10.89 - 8.11.90.

Number of sessions: 50.

5.1.1. Introduction.

Charles referred himself for music therapy, answering the advertisement published in the London Lighthouse brochure "Groups, creative and complementary therapies, activities and classes for people living with HIV and AIDS". When Charles came to see me for an initial discussion, he was depressed and ill. He had been diagnosed HIV positive for just over a year, and had recently lost his managerial position in a large corporate company. He was also having to consider relinquishing both his car and his property, due to financial constraints.

This assessment session revolved around the potential that Charles felt he had to be creative through music. He had learnt the piano as a child, obtaining Grade 4, but had not played for twenty years. Charles stressed the fact that he was not seeing the potential of our work together as life-extending, rather he felt that music therapy might offer him, through creative artistic expression, a richer quality of life. He had never improvised before, but felt that he might be able to use such a medium to explore the difficulties he was now facing. We agreed to enter into a ten-week contract, which would then be reviewed. Charles also enrolled for art therapy.

5.1.2. Description of the Therapeutic Process.

5.1.2.1 Sessions One to Ten.

Charles found no difficulties in exploring through improvisation. The initial sessions (one to five) were taken up with musically exploring the potential sounds of all the percussion instruments, including the piano. Verbally during this time we explored the boundaries that we might set in translating the musical experience into words. Words for Charles were important, and he could talk at great length about many issues both personal and political. The problem we both foresaw was that it would be easy for the sessions to become too broad. It was therefore agreed that we would keep the aims of each session to his personal state at that time. Longer term aims would be discussed after the initial ten sessions.

By session ten it had become apparent to both Charles and myself that his self-expression through therapeutic improvisation was already becoming an essential part of his life in facing the difficulties of his present situation. We agreed during this session that our work would extend to a longer-term contract. It was decided that the aims for the sessions would be :

- 1) to refine the process of utilising therapeutic improvisation in mirroring Charles's personal states
- 2) to find a balance between words and music, which adequately balanced the therapeutic outcome, and which would give the best results for Charles's needs

3) to focus and extend the periods of complete release, ("Elements of communication" see 1.4.2.) as the therapeutic relationship evolved

4) to have the facility for Charles to listen back to the sessions on his own during the week, and thus extend the potential benefits of the therapeutic process.

Once it had been agreed that our work together would be extended, the progress of the therapy during the sessions became far more intense and forward-looking. By session ten, Charles wrote to me in the form of a letter :

" A few words to try and express my thanks to you for the music therapy which has become such an important part of my ability to maintain my health. In the beginning I did not know what to expect, nor realise how music therapy could help someone to get better from their illnesses, but after a few sessions, once the trust between us had been established, I started to understand the importance of searching within ourselves for the key to some of the answers. Having the facility to express oneself through music, without the constraints of technical or learned ability, enabled me to express my feelings in a totally new way. Listening to the tapes we made allowed me to explore what was produced, musically, at various points in time, which gave me an insight into the way I was feeling and the way I interacted with people, depending on the environment I was exposed to during the week. This additional facility for monitoring one's feelings has helped to establish a balance, with the result that I am more able to tackle any diseases and difficulties which come my way."

5.1.2.2. Sessions Eleven to Fifty.

The therapeutic relationship now became finely tuned. Through wild improvisations, Charles was able to explore issues of anger as well as exultation. Alongside these more extrovert musical expressions, he found great strength in utilising what became a finely tuned ability to express tranquillity and pain, through the minimum of notes.

The sessions evolved into the following stages :

- 1) Verbal dialogue. An exploration of Charles's feelings.
- 2) Improvisation number one. Normally no set theme, musical or therapeutic, would be decided upon. This would be the longer of the two improvisations and would normally be extrovert, reaching an elongated climax towards the end, leaving Charles physically and emotionally empowered.
- 3) Verbal reflection.
- 4) Improvisation number two. This would normally be shorter, and of a more inward-looking nature. The therapeutic avenues would normally be more refined and Charles would often suggest a theme musical, and/or therapeutic.
- 5) Verbal reflection.

As the sessions evolved the use of musical idioms became more refined. His technical ability in being able to accommodate these musical needs, also became more developed. The music would fall

naturally into a mode or scale, mirroring his personal state. He favoured the “middle-eastern” and “Spanish” idioms (see below) for the more extrovert and aggressive avenues, and simple scales, including B flat and E flat, for the more reflective moods.

The term “middle-eastern” discussed within this chapter is based on the following scale :



The term “Spanish” idiom used during the sessions was based on the following harmonic progression :



His use of instruments became specific. From session eleven onwards, the piano became the main vehicle for expression, the percussion being employed only as a means to explore those times when Charles felt specifically annoyed or aggressive. He found both the specificity of tones, as well as the percussive qualities of the instrument, crucial in expressing his needs musically.

Charles entered into the research project with excitement. He was eager to see what his improvisations might look like transcribed and was pleased that this might help the furtherance of music therapy for people living with the virus. We discussed how the boundaries of the therapy might change when he came to the university for the computer based session and how that would consequently affect the findings.

Charles came to the University (session thirty-one) distraught, due to the fact that a close friend had recently died. After the session he was to attend the funeral. The two improvisations were clearly representative of the form that had been established : a longer improvisation demonstrating his emotional distress through perseverative rhythmic playing, as opposed to a more inward looking second improvisation in B flat major.

The assessment session that followed a month later, from a data collection perspective, was disappointing. Charles found difficulty in recapturing the mood of the session and resorted to an oversimplification of language.

Issues of counter-transference, were crucial in clearly placing my reactions and the effects they had upon the therapeutic relationship. Initially I felt a sense of achievement in my role as therapist, due to the fact that clear physical manifestations were taking place as a direct result of the therapeutic intervention. Associated with these feelings of personal achievement evolved a dual representation : the relationship set up through music, and the “outcome” result that music therapy did have a positive effect upon on Charles’s health.

In psychotherapeutic terms, the “broad spectrum”, (Winiarski 1991) (see 4.1.2.4.) contained issues that should be noted. Charles was of an outgoing and friendly disposition, he rarely missed a session and would often complement me on my ability to provide the “right” music necessary for the avenues we were exploring. He would make clear those times that he was angry or upset, and would always see the improvisations as being the main medium to express and clarify these feelings. The “narrow spectrum” was more complex : how effective was I in containing Charles’s inclination to use the sessions as a means to explore verbal avenues not always directly associated with the therapeutic direction, and how much was I allowing Charles to manipulate the sessions, in order to avoid the more subconscious issues connected with his HIV status ?

It appears that whilst initially Charles did not view music therapy as an agent for the extension of life, by session ten via his letter, this in fact had become the case. His documentation illuminates the fact that he was able to use music therapy as an anchor for situations outside the sessions, which in turn affected his personal state and thus potentially the psychoneuroimmunological influences on that stage of the virus.

Attributing to one particular therapeutic intervention the cause of a change in a person's health, must be a matter for caution. The fact was, however, that after ten weeks of art and music therapy, Charles's health began to improve dramatically. His general disposition became much more level and physically he began to put on weight. Perhaps it would be more pertinent to view this change in terms of artistic creativity, rather than one of particular medium.

The balance in the sessions between verbal dialogue, and the two distinct forms of improvisation (extrovert and introvert), became a formula which enabled Charles to balance his feelings in a format that expressed and then contained these feelings as opposed to the issues that were raised for him during the week. The actual musical content of the improvisations in themselves became crucial in mirroring his state at that time. The "middle-eastern" mode (see 5.1.3.) became a symbol of strength, power and aggression, whilst scales and modes within a clear major/minor orientation displayed his feelings of sadness and tranquillity. These therapeutic and musical paradigms within themselves became finely tuned as the therapeutic process progressed. They finally represented an exact mirror of what Charles was feeling at the time of each session, thus giving him the opportunity to explore *these issues non-verbally in a very exact and pertinent manner.*

5.2. Stage Two. An Integral Investigation.

Player classifications :

Player one - Therapist = (T) P1

Player two - Client = (C) P2

5.2.1. Principal Improvisational Schema.

The main musical structure from 0:00 - 11:16 revolves around elements of perseveration, initiated from (C) P2. The musical themes of (T) P1 improvised around the perseverative figures of (C) P2 are based on the evolution of two main contrasting ideas : a) first initiated at 2:08 and b) first initiated at 5:24. At 11:50 - 15:06 the music takes a new direction moving towards a slower tempo invention.

At certain points within the improvisation, bridge passages are employed. These fall into two distinct categories :

a) resting bridges - bridge passages that act as a pause between thematic developments. They contain no musical ideas congruent with other musical material.

b) developmental bridges - bridge passages that act as pauses within the musical development. They contain musical ideas and themes that are directly related to the surrounding musical invention.

5.2.2. Aspects of Metric Transcription.

Due to the regular rhythmic content of the vast majority of this improvisation regular bar-lines have been inferred. Whilst being

recommendations only (they are included on the full-score as dotted-lines) in content, they do allow for greater freedom in pin-pointing specific sections of the improvisation necessary for the rest of the analysis.

5.2.3. An Inventory of Musical Interrelations.

The improvisation has been divided into four main sections :

Section one - 0:00 - 2:08 Introduction. (Exposition)


Section two - 2:08 - 11:16 tempo - fast.

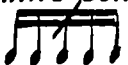
Section three - 11:16 - 14:35 tempo - slow.

Section four - 14:35 - 15:06 coda.

Section One 0:00 - 20:08.

0:00 - (C) P2 begins the improvisation with slow forceful chords tonally based around C minor. (T) P1 answers with atonally structured chords, unrelated to the C minor key centre.

0:15 - a regular perseverative rhythmic structure is introduced from (C) P2. (T) P1 answers each pulse with four phrases of two measures each, followed by one phrase of three measures ( = 80).

1:16-1:50 - (C) P2 continues with the perseverative rhythm, harmonically contained within the C minor key centre. (T) P1 condenses the answering phrases initiated at 0:15, developing them in two forms : a) free rhythmic configurations contained within the pulse (notational realisation ) , and b) in tempo configurations.

1:34 - (T) P1 improvises melodic intervals generally contained within the middle-eastern mode based on D (see 5.1.3.).

1:50-2:02 - (C) P2 moves the harmonic base to the first inversion of C minor. Notes outside the C minor tonic triad are introduced in the right-hand. (T) P1 expands the phrase lengths, juxtaposing free rhythmic and in-tempo phrases. Harmonically (T) P1 is atonal.

2:02-2:08 - this span structurally can be viewed as a connecting passage leading to 2:08. (C) P2 returns to the tonic triad (C minor), (T) P1 responding with an ending phrase that concludes the exposition.

Section Two. 2:08 - 11:16.

2:08-2:21 - the main section of the improvisation begins to develop, the first of the two themes discussed in 5.2.1. being improvised by (T) P1. This theme produces a syncopation between both parts (2:08 - 2:21), motivating (C) P2 to deviate from the perseverative rhythmic playing so far employed.

2:21-2:59 - a melodic line in octaves is stated by (T) P1, which is contrasted by (C) P2 who improvises tones 2, 3 and 4 of the middle-eastern mode. (see 5.1.3.) This is further developed by (T) P1.

2:59-3:28 - theme b (T) P1 (see 5.2.1.) is stated embryonically in the form of two chords. This is followed by a syncopated passage based on two chords contained within the middle-eastern mode. (see 5.1.3.)

3:28-3:38 - a short developmental bridge momentarily acts as a resting place from the driving force of the music. A displaced melodic phrase, based on the middle-eastern mode, is combined with a slower tempo (C) P2.

3:38-3:55 - the driving tempo of the improvisation returns, with repeated chords improvised by (T) P1. They are harmonically based on the middle-eastern mode with an added D flat. An *accelerando* (3:42 - 3:52) gives rise to the first independent melodic invention from (C) P2.

3:55-4:26 - this section gives rise to freer rhythmic configurations, with (C) P2 developing further extended melodic phrases in the r.h.

4:13 - (C) P2 returns to the perseverative rhythmic tempo on the tonic chord (C minor). (T) P1 during this passage developing melodic inventions loosely based on the middle-eastern mode.

4:26-4:50 - this section is static developmentally and can be categorised as a resting bridge. The perseverative tempo continues (C) P2, overwhich (T) P1 weaves short free phrases culminating in a displaced melodic-line at 4:46.

4:50-11:01 - this heralds the development of themes one and two proper. (see 5.2.1) Each player retains his own individual tempo producing rhythmic syncopation. Theme a is developed into longer phrases often with concluding short tail-phrases of displaced melodic tones.

5:15-5:24 - a developmental bridge.

5:24-5:42 - theme b is stated in its first full form (T) P1. (C) P2 shifts the harmonic base to B natural.

5:42-6:09 - theme one (T) P1 is extended, followed by an extended tail-phrase.

6:09-6:23 - two shorter statements of theme one (T) P1, plus tail-phrases are played.

6:23-6:27 - a resting bridge. During this short section (C) P2 begins to improvise rising and falling melodic lines. The passage is overlaid with short phrases from (T) P1 originating from theme a (see 5.2.1.).

6:27-7:36 - this span contains an interplay of themes a and b (T) P1 (see 5.2.1.), which become shorter and more compressed. (C) P2 continues to develop the melodic inventiveness incorporating notes of the middle-eastern mode.

7:36-7:45 - a resting bridge. (T) P1 improvises a single-note melodic line.

7:45-8:15 - the interplay between themes a and b (see 5.2.1.), now becomes more condensed.

8:15-8:24 - a resting bridge. (T) P1 improvises a melodic line in octaves.

8:24 - the differential components of themes a and b (see 5.2.1.) now become less clear and the two themes develop variationally as the section develops. (8:31 - 8:40).

8:31 - this can be classed as either an extension of theme b, or as a resting bridge.

8:39 - theme one is improvised freely leading to at 8:40, a statement proper of theme b. The condensation between themes becomes compressed with a new theme being introduced to balance theme a (9:10). This dialogue is immediately compressed and stated three times.

9:35 - theme b is improvised P1 (T), followed by a development of four short phrases.

9:50-10:34 - themes a and b are developed freely.

10:34-11:01 - (C) P2 the tempo becomes more flowing and less rhythmic. The left-hand tonal centre is based around D flat/C sharp. This section is developed with short phrases from (T) P1, gradually shifting back to the perseverative rhythms prior to 10:55.

10:55 - (T) P1 recapitulates theme one in a faster tempo.

11:01-11:16 - (C) P2 rests on fast, single repeated notes (C natural, D flat and D natural), whilst (T) P1 plays theme two bringing this section to a final resolution.

Section Three 11:16 – 14:35.

11:16-11:50 – the key centre returns to the original tonic (C minor) (C) P2, the E flat being replaced with an E natural changing the key to C major. (T) P1 improvises melodic configurations until 11:29, when theme b (see 5.2.1.) is played twice, gradually dispersing at 11:50.

11:50-12:35 – (C) P2 revolves the harmonic base around chords one (tonic) and five (dominant) in C major, with a two-part melodic invention interweaved by (T) P1.

12:26 – (T) P1 hints at theme one (see 5.2.1.)

12:35-14:35 – (C) P2 continues with a slow regular pulse. (T) P1 develops a more continuous melodic line of *tones unrelated to (C) P2*, with a swaying phrase at the end that becomes developmentally important later in this section.

13:33 – (C) P2 begins a melodic invention based on the moving configuration (T) P1, first improvised at 12:35.

13:57 – a developmental bridge. This passage acts as a small recapitulation period before the coda. (T) P1 continues the simple accompanying melodic line (see 12:35), doubling the tempo briefly at

14:11-14:16 – (C) P2 combines previous motives alongside the rising theme (T) P1 improvised at 12:35 : i) 13:15 octave configuration, ii) 14:07 theme 12:35, iii) 14:11 theme one (see 5.2.1.) iv) 14:16 theme 12:35, followed by an ending phrase 13:33 and v) 14:32 theme one. (see 5.2.1.)

Section Four 14:35 – 15:06.

(C) P2 returns to the C minor chords of the opening, whilst (T) P1 responds with displaced chords. (C) P2/(T) P1 combine at the forth measure, beginning a grand accelerando of monolithic-type chords. This becomes a gradual rallentando through to the dynamically loud conclusion.

5.3. Stage Three. Two Constituent Analyses.

Analysis one : 7:07 – 8:07.

Analysis two ; 11:16 – 14:35.

5.3.1. Analysis One.

There was general agreement from the external validators, plus the client, that a change had taken place at this point within the improvisation:

"I stopped the tape at the moment where the bass part just began living. A movement has definitely taken place." (Counsellor)

"The whole character of the improvisation now appears to be different. There is a general clearing of the overall texture." (Musician)

"That moment feels like a real landmark from what we have heard before. It's like it has moved into a different phase." (Music Therapist)

"It sounds like the bass heart-beat, which is giving the giant's heart-beat. Its got faster, the giant is giving more energy." (Charles)

By considering the improvisation prior to this extract, it is possible to place the forthcoming analysis in a more justifiable context. Tonally the improvisation preceding 6:54 is based on C, the key-centre is then shifted to D. This key-centre transformation affords an uplifting quality to the whole texture of the improvisation. From 6:23, (C) P2's right-hand configurations move from repeated notes to more melodically informed phrases, thus according a more equal weight to the overall musical inventiveness. This assumption is confirmed by the

musician and the music therapist :

" The musical language of the bass up until now has consisted of a driving rhythmic pulse, generally constant in tempo and harmonic structure. The treble has striven to place this perseveration (see 1.5.3. p 55) within a more inventive musical context. Now the bass begins to develop more melodically informed phrases in the r.h. This changes the whole improvisational relationship, in that both players are nearer to becoming equal in terms of musical invention. The treble continues to develop the material previously improvised." (Musician)

"Player two is beginning to become more precise, rather than the massive uncontrolled noise. This is the first time where I have been able to hear some kind of figure, in his right-hand. He is playing some kind of scalar configuration, whereas before I felt that he was only making noise. Here is structure and form." (Music Therapist)

The tonic key-centre change, plus the inception of more melodic phrases, ((C) P2) whilst forming a subtle developmental change within the overall structure of the improvisation contains an essential relationship change. (T) P1, by 7:07 has consolidated his musical inventions in the form of two main subjects which are now explored with focus. (6:54 and 7:01). The contrast of individual musical ideas when combined, forms an overall structural unity. This concept is explored by the music therapist :

"There is a certain sort of inevitability about what player two is doing. He is playing something very simple. It is moving around, and what is happening to the mood, is that it is changing all over the place. What player two is doing is very simple, and what player one is doing is everything else. There is such a contrast from what player one is doing, and yet it

fits together. It's a whole, it's not like two independent people doing their own thing, it's like a duet, like one unit, even though player one is playing something completely different from player two, both as regards pitch, harmony, rhythm and everything." (Music Therapist)

The apparent difference, yet overall unity of invention, between both players can be viewed both as an independent musical development, and as an integral part of the therapeutic direction. From a subjective viewpoint, it could be proposed that Charles at this point within the music therapy relationship was able to express more independently his own musical thoughts, without direct support from the therapist. The therapist's role thus necessitated more subtle and less direct reflections and responses. To have met his thematic inventions directly at this point would have induced a simple and banal response to what had now become a complex and intricate musical procedure.

In considering analytical procedures which will highlight and focus on the specific therapeutic and musical constructs that go to make up the therapeutic improvisation as a whole, this sectional analysis will be investigated in terms of a) musical and therapeutic perseverativeness, b) harmony, c) melody, d) rhythm and e) gestural and textural devices. A condensed representation of the three main seed motives of this sectional analysis will initially be proposed, displaying the overall structural design, from which the rest of the component analyses can be anchored. (see Figure eleven) The condensation is further divided into three basic thematic forms. The two statements of the thematic subject three are thematically linked and in structural terms the two shorter exploratory combinations (1,2.) are followed by a more unified expression. (3,3.)

The image displays a handwritten musical score for a piece titled "Figure Eleven." The score is organized into three systems, each consisting of four staves. The notation includes various musical symbols such as chords, scales, and section markers.

System 1:

- Staff 1 (Treble):** Starts with a key signature of one flat (B-flat) and a time signature of 7/10. It features a series of chords and a section marker labeled (A). The key signature changes to two flats (B-flat, E-flat) for the remainder of the system.
- Staff 2 (Treble):** Continues the harmonic progression with chords.
- Staff 3 (Bass):** Features a series of eighth notes, with a bracket indicating a group of four notes.
- Staff 4 (Bass):** Features a series of eighth notes, with a bracket indicating a group of four notes.

System 2:

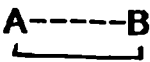

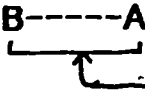
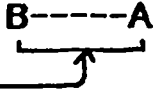
- Staff 1 (Treble):** Starts with a key signature of two flats and a time signature of 7/11. It features a series of chords and a section marker labeled (B).
- Staff 2 (Treble):** Continues the harmonic progression with chords.
- Staff 3 (Bass):** Features a series of eighth notes, with a bracket indicating a group of four notes.
- Staff 4 (Bass):** Features a series of eighth notes, with a bracket indicating a group of four notes.

System 3:

- Staff 1 (Treble):** Starts with a key signature of two flats and a time signature of 7/14. It features a series of chords and a section marker labeled (B).
- Staff 2 (Treble):** Continues the harmonic progression with chords.
- Staff 3 (Bass):** Features a series of eighth notes, with a bracket indicating a group of four notes.
- Staff 4 (Bass):** Features a series of eighth notes, with a bracket indicating a group of four notes.

The score concludes with a section marker labeled (A) in the final system.

Figure Eleven.

Seed Motives				
Thematic Subjects	1	2	3	3

Throughout this section (C) P2 continues in a quaver pulse, at a more or less even tempo. The accents and cross-rhythms are influenced by (T) P1, though they do not directly alter the groupings of the continuous pulse.

5.3.1.1. Elements of Perseveration. (see 1.5.3. p 55)

Throughout the whole of section two (2:08 – 11:16, see 5.2.3.) the musical structure and form is directed from (C) P2, through strong regular playing, which soon becomes perseverative in content. On one hand this musical style provides a uniformity of musical direction, whilst on the other it initiates a confinement of possible contrasting invention. By 7:07 this format is well established. In this sectional analysis (T) P1 decorates the regular pulse with ideas that are at times coincident, (7:36) (subject C), (7:07) (subject A) and at times that are in direct rhythmic opposition (7:11) (subject B).

Therapeutically, the perseverative playing caused the counsellor to respond, and look for deeper reasons behind the actual musical content itself :

As the improvisation progresses, I have a question which poses itself in terms of player two, and that is "what is it to be still ?". I think player two for

some time has found it quite difficult, or certainly hasn't had many spaces, whereas the top register has allowed the space to occur quite frequently. It certainly seems as though the bottom register is in some way stuck and finds it quite difficult to be still, to be silent for a while. It does feel that there is in some form of will finding it difficult to escape, to stand still and reflect. So in fact the reflection is coming from the top part. The more you hear the music the more painful and disturbing it becomes, and leaves you with the question, "well maybe this person is still, maybe somewhere the life force is quite dead. ?" That the person hasn't got the energy somewhere. The energy is coming from the middle to the top half of the piano. That is what is keeping the music alive." (Counsellor)

By considering both the broader implications of Charles's stage within the therapeutic process, plus the conditions set up within this actual session, it is possible to find clear reasons for this style of playing. Charles was now able to utilise the therapeutic improvisation to exactly mirror his feelings. During this stage within the music therapy development, Charles was beginning to explore the darker aspects of his life, using music to relay conscious and subconscious issues directly related to death and dying. As discussed in the idiosyncratic description (see 5.1.4.), Charles had recently experienced the death of a friend and was to attend his funeral directly after the session. It is not surprising, therefore, that this perseverative playing should form the initial section of the improvisation. That the issues of death and dying were expressed directly through the improvisation, meant that the music was exactly mirroring Charles's intent. The counsellor commented on the need to be still and reflect, however it is my subjective view that at this stage it would have been too directly painful for Charles to allow himself the space to reflect. It was

necessary for me, as the therapist, to contain and contemplate rather than directly challenge. Certainly as the perseverative playing increases, it does become painful and disturbing.

5.3.1.2. Harmonic Implications.

The harmonic content of this section is significant in connecting the differential between therapeutic intent and musical outcome. The musical pain and tautness is achieved by a diacritical harmonic layering, which at its simplest level can be designated by (T) P1 utilising mainly the black-notes of the piano, and (C) P2 mainly white-notes. This section can be viewed in three possible tonal centres. (T) P1's overall key structure is based on A flat, whilst (C) P2 hints at the two key centres C and D, dually at 7:07 (D l.h./C r.h.), and separately at 7:12. (C 1st inversion-7:36.) By isolating these three possible key nuclei, it can be identified that they form three notes from the C minor scale, the overall key period of the whole improvisation. One assumption that can be extracted from this information, plus the client's evaluation below, is that whilst this passage has been identified as being an apex for change it is still contained within the boundaries of the overall harmonic expression. It thus retains and connects with the original musical and therapeutic enunciation.

**"I felt that this music was going in a new direction, but at the same time I didn't want to let go of the feeling I had at the beginning of the improvisation. I wanted to keep some part of it the same, which is why I didn't change the notes of the chords much."
(Charles)**

Seed motive A occurs three times during this passage, (7:07, 7:51, 8:00) encapsulating the three differing tonal centres mentioned above. The musician comments on the importance of the duality of harmonic content :

"I can hear quite distinctly that there are two different key centres in operation. Musically this combination makes for a harmonic basis that is both exciting immediately, but which also acts as an agent to propel the music forward. It adds a new dimension to the overall musical sound. " (Musician)

By examining the three motives, it is possible to view the disparity in musical expression discussed earlier in this section, which combines to construct a unity of complementary musical language. The harmonic differentials are subtly different for each motivic statement. 7:07 contains the triple stratum of C, D and A flat, whilst 7:51 balances C major 1st inversion (C P2) against A flat and 8:00 balances C against A flat.





Seed motive B is also employed three times within this section. The outer intervals of the configurations of (T) P1 in terms of pitch descends from B flat (i) through A flat to G. In an intervallic dissection the three statements incorporated are : a diminished sixth, a major seventh and a major ninth. By considering 7:11-7:22 as a single unit, it is possible to condense the basic harmonic structure :



What is visible here is an overall balance between (C) P2, based on D natural and (T) P1 based around B flat (1,3) and D flat (5,7,9,). This feature of duality which is so strongly identified as a musical and therapeutic fundamental throughout the whole of this harmonic investigation, is here clearly identified.

5.3.1.3. Melodic Features.

In classifying the general melodic features of both players, it is first necessary to consider the relevant observational data :







"The bass returns to the repeated-note phrases although the root notes begin to change more rapidly (7:22-7:36 D,G,A,G,E). There appears to be little actual melodic invention except for one small section (7:36-7:45) where player one unexpectedly improvises a short lyrical melody. I consider this short passage to be important in melodic terms because of what is surrounding it, and that it is not repeated." (Musician)

"I wonder why there are few melodic themes within this passage ? It's almost as if player one becomes exhausted with the driving rhythms and feels he has to play a melodic phrase (7:39). I feel that player one is tired with keeping up with player two. Its as if the pain of the driving monotonous music cannot be effectively shared anymore, and yet after a very short break player two seems to find the strength to continue." (Counsellor)

The melodic relationship within this passage, both musically and therapeutically, is significant. (C) P2 accompanies the melodic invention of (T) P1 with a two note minor chord (E,G.). The non-directive key-centre is uncommon in section one, and adds a diaphanous quality to the overall accompanying texture of the melodic line. This change in musical intensity could hold varying therapeutic and musical subjective possibilities a) has (C) P2 acknowledged the exhaustion of (T) P1, as identified by the counsellor ? b) has the preceeding driving intensity focussed itself for an instant into a passage of clarity ? or c) is there a need for a new musical development ?

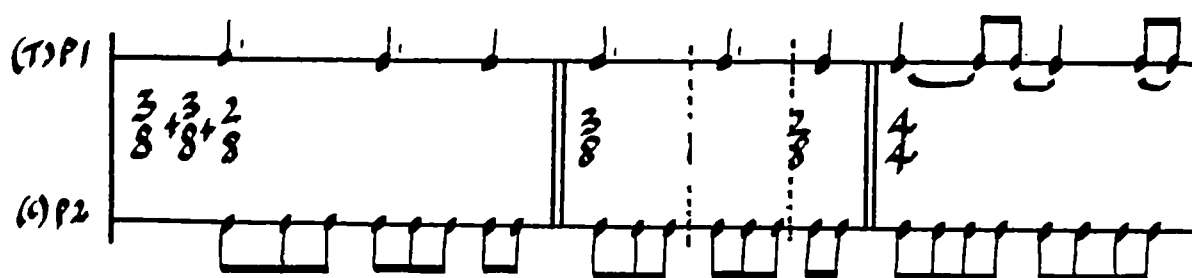
5.3.1.4. Rhythmic Components.

The three basic seed motives of this passage are transcribed rhythmically below:

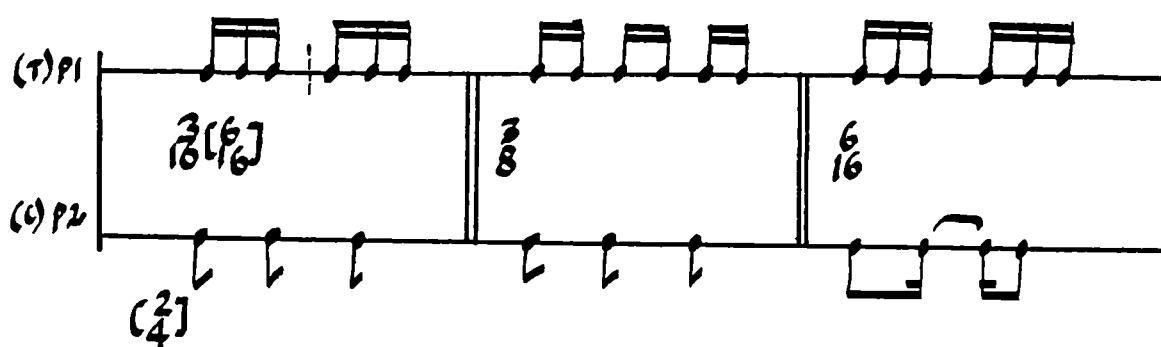
1.			
2.			
	Seed Motive A.	Seed Motive B.	Seed Motive C.

The main difference in rhythmic relationship between the three seed motives is that seed motives A and B provide a sense of syncopation between players, whilst seed motive C is congruent. Seed motives A and B form the main rhythmic core. The constructive syncopation set up between both players augments the main therapeutic and musical hypothesis of this analysis : that the disparity in expression combines

to produce a musical unit identity. By dissecting seed motives A and B further it is possible to propose various group combinations and key signatures :



Seed Motive A.



Seed Motive B.

The controlled rhythmic syncopation of (T) P1 at one level does not break (C) P2's perseverative pulse, whilst at another level it diversifies and adds a different dimension to the rhythmic content. The analytic classification of both seed motives demonstrates the possible groupings contained within the rhythmic constituent. It is not possible to make conjectural assumptions with regard to which of these groupings the improvisers adhered to. What it shows clearly, however, is that each possible combination of rhythmic emphases and stress is critical in the improvisational process and direction.

5.3.1.5. Textural and Gestural Considerations.

Charles used texture as an integral tool for expressing specific emotional concepts. As illuminated through the external validators' data (see 5.3.1.1.) it appears that Charles is not yet ready to express through the improvisation direct issues of death and dying. Similar to his rhythmic perseverative playing, Charles's chosen texture is generally constant throughout this section. (T) P1 mirrors this textural expression by utilising two clear and differing consistencies; seed motive A is broad gesturally and texturally, whilst seed motive B is more contained. Gesturally (C) P2 remained physically static throughout. Concurrently (T) P1, through textural devices of the two seed motives, alternates between the broad and contained gestural configurations.

Seed motive C (7:36) texturally, as in the analysis of the melodic features (see 5.3.1.3.), is decisive in providing a divergent musical expression in contrast to the surrounding components.

5.3.2. Analysis Two.

Structurally at 11:16, the improvisation moves into a new direction (section two). The tempo becomes slower and the perseverative rhythmic urgency of section one abates. This major change in the improvisational bias initiated comments from all the external validators, plus the client himself :

"There is now a listening taking place. This means that there has been quite a step forward in the sense of space and listening, which is so vital in the therapeutic relationship." (Counsellor)

"In terms of the musical language, this section becomes slower in tempo, clearer in texture and more extended in terms of melodic development. The passage lies in stark contrast to the driving music preceeding it, although there are certain musical elements that remain constant, most notably a consistency of rhythmic pulse improvised by the bass. So what has changed is the overall mood, bringing a sense of musical relief." (Musician)

"Suddenly it turned, the roles have been reversed. It feels like a relief, player two cadenced as well, he actually played falling fifths, it was more diatonic, and the two players are more together. I

was just very different. It felt like suddenly you both turned a corner, and then all the pace just dropped of the relentlessness of player two just went. The chord that started it off was like a falling phrase, you heard the strong followed by the weak. It was a real point of focus, and then from there the music has gone into a different direction. It is more expressive and gentler, not necessarily any less painful, but different.” (Music Therapist)

“I felt that this section should be separate, it’s as if it’s not related to anything else, that we came to the end and it seemed as if it was going to be a good ending to that whole story of emotion and peak. But it then came down, and now it is quiet. This should be a separate piece. That was enough of that life story to go after reaching such heights.” (Charles)

It is interesting to note the similarities and disparities in what this change meant to the external validators, and the client. Both the musician and the music therapist expressed a sense of relief, whilst the counsellor felt aspects of more direct listening and sharing to be the essential element. Charles saw this change as something that should have been quite separate, another piece, and in many ways unsatisfying because of this.

Therapeutically this departure into a new, less tense, section was crucial in moving into a new form of musical expression. Could this departure have occurred without the intensity of the first section and how important were these prior musical influences in affecting the shape and content of this new enunciation ? This section provided a space in which to explore the issues of section one, but in a totally different format. As the music therapist noted, the expression of pain

was no less intense, it simply changed. The client's own views are contradictory. Charles obviously felt this new transition to be difficult and somewhat redundant. This being the case, it should be questioned as to the therapeutic value of this ensuing section. Was Charles finding difficulty in expressing the painful feelings of the death of his friend through a much more exposed musical structure or had he exhausted these feelings throughout section one ? I asked Charles if he felt that the ensuing section would be superfluous :

"I think so, it's like we came to a point where it just rounded off nicely. We had really been up and then it smoothed out. I had this feeling that we had been up, and a bit tired. And then it carried on." (Charles)

In viewing this transitional section from a musical perspective, it becomes necessary to consider the musical events prior to 11:01. The beginnings of change appear at 10:34, where the tempo decreases and a more fluid phrasing is initiated from (C) P2. The thick chords disappear, and just prior to 10:55 (C) P2 concentrates on single octave playing, spread between both hands. (T) P1 re-introduces the seed motive B (see analysis one 4.2.3.1.) in the form of two short fragments. At 11:01 (developmental bridge) (C) P2 focusses on fast repeated single tones, (C natural, D flat, D natural) over which (T) P1 states the seed motive A (see analysis one 4.2.3.1.). This comes to rest at 11:16, with a positive inception of the new slow tempo ($\text{♩} = 80$).

By considering 11:16-11:29 via a three level hierarchical condensation it is possible to see the inception of the new developmental seeds (see figure twelve). By dividing the passage into two sections (A and B) and exploring the basic constructs, differing musical inaugurations become visible. A is involved with musical

Handwritten musical score for Figure Twelve, showing three levels of musical analysis. The score is organized into three horizontal sections, each labeled "LEVEL I.", "LEVEL 2.", and "LEVEL 3.".

- LEVEL I.** (Top section):
 - System 1: Treble staff (T)P1 and Bass staff (C)P2. Time signature 11:16. Bracket A spans the first part, and bracket B spans the second part.
 - System 2: Treble staff (T)P1 and Bass staff (C)P2. Time signature 11:29. Bracket A spans the first part, and bracket B spans the second part.
- LEVEL 2.** (Middle section):
 - System 1: Treble staff (T)P1 and Bass staff (C)P2. Bracket A spans the first part, and bracket B spans the second part.
 - System 2: Treble staff (T)P1 and Bass staff (C)P2. Bracket A spans the first part, and bracket B spans the second part.
- LEVEL 3.** (Bottom section):
 - System 1: Treble staff (T)P1. Bracket A spans the first part, and bracket B spans the second part.

Dashed lines connect notes across levels, indicating relationships between the different levels of analysis. The labels (T)P1 and (C)P2 are used to identify the parts.

Figure Twelve.

issues and relationships of section one (C minor tonality (C) P2/opposing melodic invention (T) P1), whilst B looks towards a more unified musical expression contained within the white notes of the piano. Level one of the condensation provides the full-score from which the micro examination of levels two and three are taken. The above assumptions can be seen clearly through level three with the tonal core relationship between A, the semitone, and B the major third.

5.3.2.1. 11:29-12:26. Improvisational Development.

"Player two is now more tonal with both hands. Player one keeps bringing in shades of what we have heard before from the first section, and it feels odd musically but therapeutically I would suggest that it is necessary. Player one is quite atonal, even though player one is now more tonally melodic. For player one to have gone into the same key would have felt rather superficial, a bit contrite. It wouldn't have expressed the intensity, it's like the music is still amongst the pain of what had gone before." (Music Therapist)

"I think this new movement is very much to do with player two allowing himself the space to listen. To listen to what is happening from player one. Now the music is able to move on to be a part of the listening, so in fact silences are shared even though player two is still very repetitive, and in a sense quite predictable." (Counsellor)

"At the inception of this section the bass infers a C minor tonality which then moves to C major (11:16). A slow-moving constant pulse provides a similar stability to that found in the first part of the improvisation. The treble responds with a new lyrical three-note phrase, followed by a statement

of the syncopated invention previously improvised. This acts as a thematic bridge between both sections. A new melodic line is developed and extended by the treble (11:59), with a further extension of the previous thematic material" (Musician)

It is pertinent to analyse this passage from both the therapeutic and musical perspectives. As the therapist I was aware that this new section should not be treated as a totally new expression. The continuation of ideas described in the previous sectional analysis (11:01-11:29), were further developed in this section and can be clearly seen from a skeleton representation (see figure thirteen). It is possible to classify therapeutically/musically three distinct elements:

- A) concerning section one schema - previously heard musical and therapeutic elements. (including seed motives A and B, see 5.3.1.)
- B) concerning section two schema - music and therapeutic elements intrinsic to this section.
- C) concerning section one/section two schema - music and therapeutic elements of both the preceeding sections and this section.

The classification of improvisational ideas (T) P1, hints at the calmer less tense expression that is developing. (C) P2 whilst still retaining a slow constant pulse, texturally refines the content of tones and intervallic development. From measures one to four, the alternation of elements A and B is clearly visible, merging into the less defined and less taut parallels of element C. From measures ten to seventeen there is an extended development of element C, with longer drawn-out

Handwritten musical score for piano, consisting of four systems of staves. The first system is labeled (c) P1 and (c) P2. The notation includes various musical symbols such as notes, rests, and dynamic markings. Below the staves, there are handwritten annotations: (A), (B), and (C) with arrows indicating specific musical elements. The score is written in a clear, legible hand.

code: (A) (B) (C) Musical and therapeutic elements see 5.3.2.1.

Figure Thirteen.

phrases. At measure seventeen (C) P2 slips into a less clear tonality which immediately initiates a return to element A, containing a tail-phrase which extends the seed motive A of this section to double its original length. At measure twenty-two there is a clear reference to the seed motive B, (see 4.2.3.1.) leading into an intermediary passage of element C.

Harmonically, melodically, rhythmically and therapeutically, what transpires throughout this passage is a solidarity of expression. The subtle musical indirectness and harking backwards appears to have been instrumental in retaining the pain that had already been expressed.

5.3.2.2. 13:33–14:07. A Melodic Development. (C) P2.

At 13:33 (C) P2 initiates a single melodic-line. This change in the improvisational content produced comments from the client and the three outside validators :

“I feel that this small section, for me is where I have been trying to get to throughout the whole improvisation. When this slower music began, at first I thought it was wrong, and should have been a separate piece, but here I realise that I did have something different to say that was connected to the first part. I was able to express the pain that I was feeling through this simple melody.” (Charles)

“A new moving melodic theme is improvised by the bass. The established tonality is C minor and the melodic line of the r.h. appears to be based around the nucleus of E flat, C and G. Player one incorporates contrary motion phrases focussed around E flat, D and D,C. The melodic inference returns to the treble (13:57), with a descending

phrase in octaves resting on B flat. The importance musically of this section is the more equally-weighted content of musical invention. (Musician)

"It feels as though player two is actually taking on the melody here, which I think is the first time this has happened. Player one is accompanying him, before I think we were lucky if we heard a differentiation of pitches, let alone a melody. Player two has not only taken on something melodic with the right hand, but he also joins it with the left hand, so you have got him really saying something much more openly. It feels like quite a bold step compared with before. The melodic line has a key centre, and it is minor, what a surprise!" (Music Therapist)

"This leaves you with a sense of fear in a way, of moving away. Of there being strong fear in the bottom register and of moving away within the relationship, but actually allowing somewhere within that to listen." (Counsellor)

This section can be seen to contain the complete therapeutic and musical crux of the whole improvisation. It is important to consider 12:35–13:33, because this passage has a bearing on the musical ideas presented by (T) P1 from 13:33. Just after 12:35 (C) P2 settles into the white notes of the piano, that was striven for previously. Player one continues to promote the semitonal tautness basing the arched phrases (♩), on D flat. At 12:53 a simple melody (♩) in octaves is developed, a tail-phrase is repeated (♩), followed by a repetition of the previous melodic invention. A second tail-phrase (♩ ♩) leads into 13:33. These two musical ideas emerging from (T) P1, a) arched quaver phrases and b) octave melodic figures, form the main musical components in accompanying (C) P2's melodic motive.

The structure of the melodic line improvised by (C) P2 (r.h.) can be isolated and phrased accordingly :

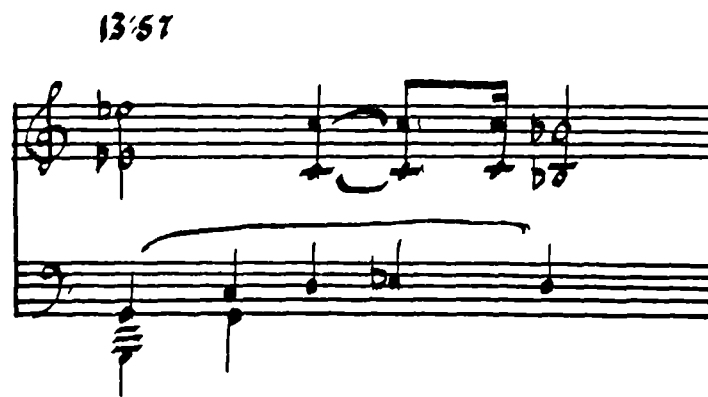
The image displays a handwritten musical score for piano, consisting of two systems of staves. The first system is labeled (C) P1 and (C) P2, with a time signature of 13:33. The second system is labeled 13:57. The notation includes treble and bass clefs, various notes, rests, and dynamic markings like '8b.....'. The score is written in a fluid, handwritten style, with some annotations above the staves.

Melodically the tones are contained within an octave, and the key-centre is C minor. By considering a melodic segmentation of this passage it is possible to discover three main core phrases (A,B,C.) with two additional tail-phrases (Ai, Ci) that are essentially connected to the overall shape of the melodic line.

Handwritten musical notation for a 13-measure improvisation in C minor. The notation is divided into three systems. The first system (measures 1-4) is labeled with 'A' and 'Aí' above the staff. The second system (measures 5-8) is labeled with 'B' and 'C' above the staff. The third system (measures 9-13) is labeled with 'C' and 'Ci' above the staff. The notation includes a treble clef, a key signature of one flat (B-flat), and a 4/4 time signature. Measures are numbered 1 through 13 below the staff. Brackets and slurs are used to group notes and indicate phrasing. The notation is handwritten and appears to be a musical score for a solo instrument.

Measures one to six are melodically contained within a fifth and take their core nucleus from the tones E flat, D and C. This presumes an overall key centre of C minor, the opening key of the improvisation (see 5.2.3. section one 0:00-11:16). Segment C revolves around the tones B, G and G, returning to a C minor tonality at Ci.

The musical and therapeutic relationship at this point can be seen to be complex in format. The therapeutic expression translates through to the theoretical musical dimensions of this section of the improvisation. Melodies and phrase shapes are carefully crafted to produce a balanced expression of musical ideas, whilst still defending an independence of inventiveness. The octave melody (T) P1, (13:57), which can be compared with 12:53 is shorter, rhythmically more complex, and melodically ends on B flat, and not the tonic C.



A comparison of melodic segmentations (T) P1, and (C) P2, further highlights their common origins (see figure fourteen.).

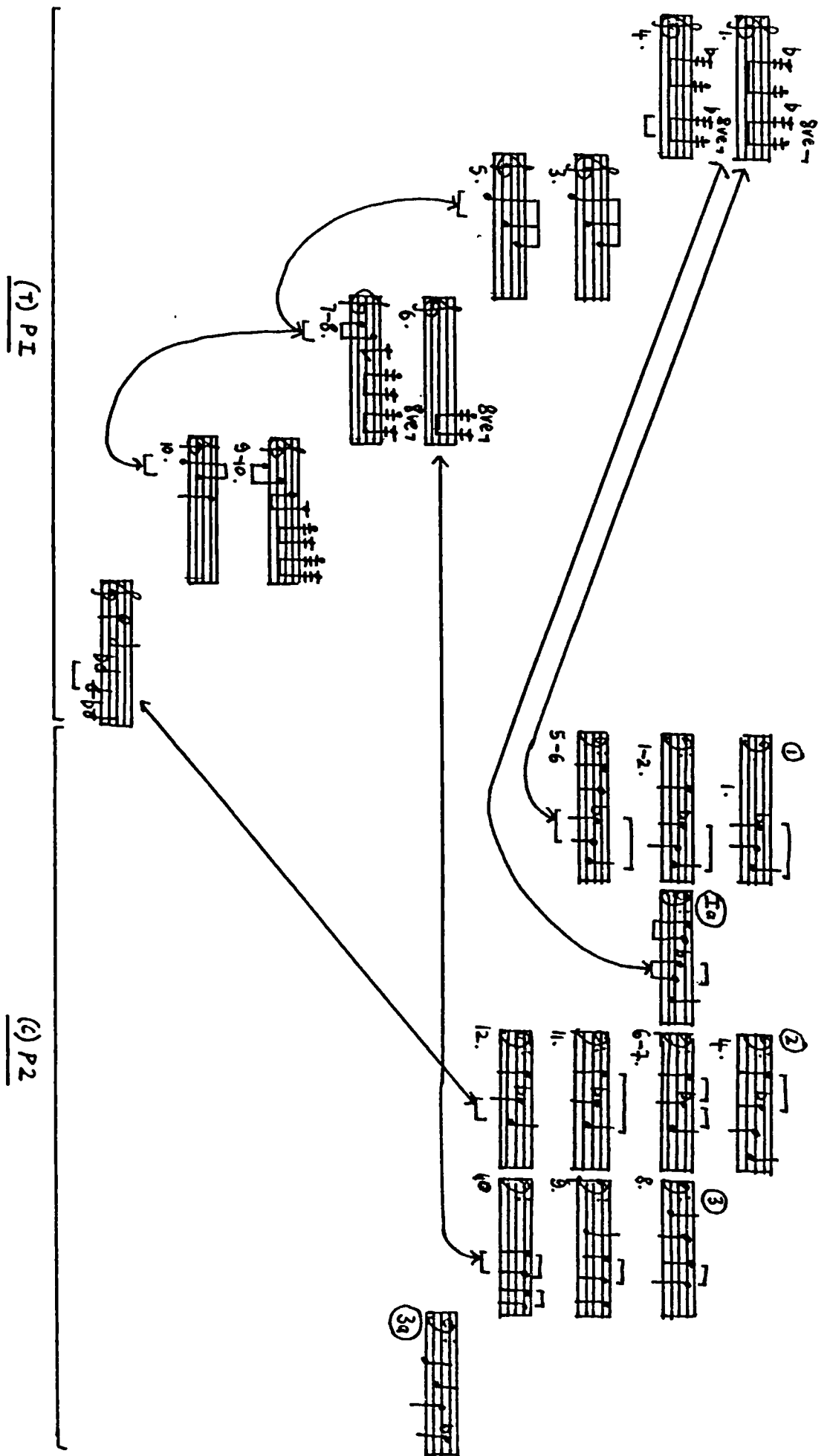


Figure Fourteen.

5.5. Stage Four. Evaluation and Synthesis.

Contained within the preceding analyses are the core aspects of avoidance : avoidance therapeutically, psychologically and musically. The relationship between the client's own assessments, the data gained from the external validators and the analyses themselves, provide a clear parallel between the intricacies of micro-analysis and the music therapy process globally. The avoidance to break free of the perseverative playing, the avoidance to explore new key centres and the avoidance of clear-textured expression and musical invention were held until the last sections of the improvisation. These musical aspects of the improvisation, in relation to Charles' psychological state, can be concluded from his own verbal assessments and from the subjective viewpoint of the author, as researcher and therapist. On one level issues of avoidance when related to issues of death and dying can be productive in protecting the individual from aspects of pain not yet ready to be experienced. On another level the relationship between the analyses, their results, and the therapeutic process as a whole, divulges criteria that in themselves are complex.

Through the preceding analyses many issues have been highlighted, not least the main musical therapeutic tool used by the client, perseveration. This musical tool can be used two-fold in such intense situations ; firstly as a tool for blocking and secondly as a means to experience and come to terms with difficult personal issues through the musical structure. It appears conclusive that for Charles in this improvisation, there was a fine dividing line between these two elements. Differing approaches to the therapeutic improvisation might have afforded divergent therapeutic consequences : a) could the direction and ultimate development into the more directly sensitive

later section have been achieved without the musical reflections of the therapist and b) could the therapist have not consciously broken the perseverative playing much sooner. ?

Through the examination of the elements of perseveration in analysis one, it transpired that certain devices were formulated by both the therapist and client for expressing emotions that were being contained within the improvisation at this time. These can be identified as follows :

- a) Charles's willingness to be affected by, but not fundamentally changed by, the therapist's musical inventions
- b) the therapist's acceptance of the situation, yet challenging it through counter-musical arguments
- c) that the product of both players produced a duality of tension and unification.

Perseveration in this improvisation was a crucial tool in exploring difficult issues for the client. During the initial stages of the improvisation the roles appear to be separate. During analysis two however, the musical expression of both players is transformed. They are still fundamentally different, yet they unite as a combined expression.

**"Both players are having spaces together and they are shared spaces, they are not individual spaces anymore. This seems to me to be a great move from the sense of stuckness and trapped imprisonment that we heard earlier in the improvisation."
(Counsellor)**

Issues of countertransference within such a context as this improvisation, which displayed raw anger and fear, are of paramount importance for the therapist to accept and reflect upon the clients needs :

"If you analyse the counter-transference, what it brings up is anger. As the therapist you must have been feeling quite a lot of frustration and anger, or that is what is partly implied. That makes me comment on what both people must have been feeling : angry, very fixed with anger and very frightened with anger. I was aware how player one was reflecting what player two couldn't say, what he found impossible to say musically. In many ways player one was saying things that player two implied, particularly earlier on, in a sense forcing player two to listen. Almost a sense of saying : "You've got to listen, you've got to give yourself space. you've got to stop it." (Counsellor)

The counsellor, in the above evaluation, encapsulates clearly my feelings as the therapist. I was acutely aware that acceptance of Charles's musical and therapeutic state was of paramount importance. Concurrently, the experience of attempting to share such strong emotional aspects of pain and aggression brought feelings for me that at times I felt unable to handle. I felt as though I was screaming to be heard musically and personally. It could be suggested that the florid inventions above the perseverative bass were in fact my own defences in wanting the playing to stop. By incorporating different musical

figures, was I in fact protecting myself ?

What is highlighted throughout these analyses are complex hierarchical procedures both musical and therapeutic. The detailed investigation of these analyses has afforded us with a greater glimpse into the relationship between musical and therapeutic intent, its effects on the therapeutic/musical relationship, and how with such insight a similar situation with the same client might be better addressed in further music therapy situations.

"The inevitability really came through in this improvisation." (Music Therapist)

"This has been quite a difficult improvisation to comment on, because of the fixed position." (Counsellor)

"Throughout this improvisation we embellished and unfolded the story." (Charles)

Chapter Six.

Analysis Three. Francis.

6.1. Stage One. An Idiosyncratic Description.

Dates of intervention. 9:11:89 - 6:12:90

Number of sessions : 32

n.b. Francis's comments during the description (apart from extract, session 26.) have been taken from the assessment session.

6.1.1. Introduction.

Francis referred himself for music therapy, during a two-week stay in the residential unit of London Lighthouse. He requested an assessment session to ascertain a) what music therapy was and b) if it could be of help to him. Francis had been diagnosed as carrying the A.I.D.S. virus and was physically weak.

The assessment session that followed that afternoon, focussed on his past musical history. Francis had studied the piano to a professional standard, attending the Guildhall School of Music and Drama and at one time having studied under Glenn Gould. He stressed the problems he had faced from family and friends, in aspiring to be a professional musician. Shortly after completing his studies, he decided against a career in music and emigrated to Argentina to become an interpreter. He subsequently had not played the piano for about fifteen years before our meeting.

The apprehension at re-establishing a connection with music was clear. He explained his thoughts on whether or not it was a good idea at this stage in his life, with death now a reality, to rekindle an area of

his life that had caused him so much pain. I explained that the work that I was undertaking at London Lighthouse was to explore through improvisation, and that I had no expectations of a pre-requisite musical standard. A discussion followed about Improvisation and the fact that he had been told during his training that he could not improvise and that it was a specialist area for Jazz musicians or those exceptionally talented within stylistic confines. I assured him that every one could improvise even without musical knowledge, and suggested that we might take the time in this assessment session to explore an improvisation together on the piano. Francis reluctantly agreed. I felt at this stage that it was prudent to facilitate a musical experience, rather than for Francis to leave with a theoretical, rather than a practical, impression.

From the moment that Francis started playing a stream of musical expression poured into what soon became a sharply focussed musical and therapeutic expression of his feelings. This initial Improvisation was untaped, and lasted approximately fifteen minutes. There was no subsequent discussion, and Francis left requesting another session the following week.

6.1.2. Description of the Therapeutic process.

6.1.2.1. Sessions One to Ten

It was decided during session one, that the therapeutic process would be ongoing. The assessment session had had a profound effect on Francis during the week, and he wished to continue exploring through a medium which he felt up until now, had been lost to him. He also expressed a wish to work only at the piano. Sessions one-ten were

therefore conducted in the form of piano, four-hands.

Francis describes the initial barriers and their subsequent resolution :

"Its all there because you have spent your life working on it, unbeknown to yourself. its a part of your life. I'm amazed at my facility. I started studying seriously late in my life, and then I stopped playing in 1976 and I hadn't played since then until I sat down with you. I was right when I was a child and I wanted to play the piano, I couldn't, there were obstacles and difficulties that I couldn't surmount. I couldn't formulate and say "I need to study music." A lot of people said that I hadn't got talent and that I should be doing something else. My own instinct was that I wanted to play the piano, and I think it seems to me the facility which comes out when I am just playing is remarkable. The sense that after almost fifteen years without playing at all, I sit down and do that. I think it must mean something. I'm not struggling to put my fingers on notes. The very first day I just sat down, I talked to you about it, I said ; "I think I've got a block, I haven't been able to play and I don't know why. I don't know why, I can't find the answer." And I sat down and improvised with you, and suddenly everything took off. After all that time if I had sat down and tried to play a pre-composed piece of music, I probably wouldn't have had the technical capacity to do it. When I'm improvising I don't worry about it, I don't think about it, not being able to do something. I just do it."
(Francis)

During these initial sessions, precise dynamics were developed which were to prove crucial for the future music therapy relationship. The sessions at this stage normally consisted of three to four improvisations, lasting approximately ten minutes each.

By session three, Francis had become self-assured in his ability to improvise to a high musical standard. It therefore became necessary for him to feel confident that I, as the therapist, was able to match and reflect his improvisations at a similar level. My musical role developed a duality, on one level concerned with therapeutic improvisatory competency and, on the other, with formulating a method of therapeutic intervention which would accommodate the needs of such a musically articulate client.

It was decided that the musical expression was the most important facet of our work and that we should not become side-tracked by endeavouring to translate music into words, without clear reasons for doing so.

Francis compares and describes the client - therapist relationship :

"How far into feelings are you as the therapist going to go ? Obviously when the client goes into feeling, the therapist, how far does he go, or does he remain on the edge of the field so to speak. ? Normally one would not go with the client, because it is not the therapist's role. But when you are playing music you can, because it's different. What is one thing in verbal therapy, but if you are both creating music, then of course if you hold back on your emotional participation you are going to fail. On the level of productivity you say, "I'm going to put up a barrier, I'm not going to invade certain areas, therefore I'm going to control the situation." Therefore of course the client is also not going to be able to travel into certain areas, because he will be restrained from doing so." (Francis)

Formulation of Aims :

1) to refine the musical components of the therapeutic improvisation, thus clarifying the musical competence of future therapeutic directions

2) to consider the verbal extension of the work, in identifying specific and pandemic approaches that would give a required balance to the musical and therapeutic direction

3) to allow the expression of death and dying, as a specific concept, to be an essential part of the therapeutic process

4) to tape all sessions and, when requested, for Francis to have the facility to re-access specific tapes, in quantifying his own therapeutic journey.

6.1.2.2. The University (Research) Session. (Eleven)

Francis was keen to be involved in the research project. He welcomed the opportunity to improvise at the university, and to take part in the following assessment session.

The session consisted of five improvisations :

- 1) Solo improvisation (Francis) (to be analysed)
- 2) Two Pianos (Francis - Therapist)
- 3) Solo improvisation (Therapist)
- 4) Solo improvisation (Francis)

5) Two Pianos. (Francis – Therapist)

Session eleven proved to be pivotal for two reasons. Firstly, this was the first time that both therapist and client had been afforded the opportunity to improvise on two pianos. What transpired through this new experience was an opening up of a more complete musical expression. Secondly, Francis had initiated the need to express himself through a solo improvisation. This was to become a crucial decision for the future therapeutic direction. It is pertinent to note also the request from Francis that I play a solo improvisation. Whilst this did not become a regular occurrence, it acted as a focus for certain cross-roads within the work where Francis required a solo musical reflection from me as the therapist. The decision to select the first solo improvisation for analysis was taken by Francis, as he felt it reflected more directly his feelings at that time.

6.1.2.3. Sessions Twelve to Twenty-Four.

The developmental change taken in session eleven effected a dramatic shift in the therapeutic direction. From this juncture Francis established the sessions into piano solos, with no musical input from myself. By session fifteen the division of three to four improvisations had shifted to one whole improvisation normally lasting between forty and fifty minutes. Verbal reflections were kept to a maximum of ten minutes. This extension to a single, solo, musical expression proved crucial in Francis exploring the issues that he was facing as his health deteriorated :

“When I’m improvising alone, I’m entirely following my own rhythm, my own inspiration. When we are improvising together, I pick up some of our rhythms.

The sum of the two gives a different result. Its almost a sense of how the tune gets changed in human lives by doing things together, rather than the increased energy input, by supporting and solidarity. Duets are less of a personal document, it's less revelatory, because if I'm working on my own it's a totally personal statement." (Francis)

The term "Active Listener" was formulated as a reciprocal concept, in identifying not only my own role as therapist, but in endeavouring to clarify precisely what appeared to be a shift in the relationship of therapist and client. There appears to be no documentation with respect to the therapist not partaking musically in the therapeutic process for an extended and regular period of time. Helmlich (1965), Alvin (Bruscia 1987), Grinell (1980) and Crocker (1957) all discuss music as a receptive medium in connection with the client in the listening role. It is not made clear, however, if these roles can be reversed and how that might affect the therapeutic outcome.

There were certain criteria that I needed to adopt in order to facilitate the future therapeutic direction :

- 1) Position - that I sat near Francis, so that I was in close proximity but did not intrude on his physical boundaries
- 2) Quality of musical listening - that I listened acutely to every musical phrase, and that I was simultaneously able to place each phrase and motive within the whole
- 3) Quality of therapeutic listening - that I considered not only the musical intricacies of the improvisation but also reflected, on the possible therapeutic connotations for a) future sessions and b) for any

verbal reflections required subsequent to the improvisation.

Both the counsellor and the music therapist identified the relationship within these new boundaries :

**"There is a sense of a very deep relationship with the therapist, even though he isn't playing."
(Counsellor)**

**"Even though you are not playing, I feel your involvement, especially in the silences."
(Music Therapist)**

Francis comments on the therapeutic process from the client's perspective :

"When I come here, I have no idea of what is going to happen, or what I am going to do. There seems to me as though there has been change, and at the time I'm sure there is continuity. Initially I had this tendency to think in terms of one, one whole. Now I have become aware of the fact that I see a whole in a larger unity of three or four parts. Not exactly sonata form, which I've always eschewed, and rather disliked, but in a sense that I understand that there is a connection between having different movements. That you can actually fulfill an expression, and that will then open up ineluctably, that it must follow, something else is waiting to be expressed. There is that continuity of feeling which actually implies a change of feeling, because you have actually expressed something, and come to a temporary conclusion, like a colon, or a semi-colon, and then there is something to add to that. I think it does rather still place the initial thing into the major position, at that moment that you.... the first.... movement, for lack of another word, remains the key

and the rest follows. That is the core is that first movement, and the rest can therefore, I'm not quite sure whether it's a contrast or a feeling sometimes, or the need to balance something, I don't know. Its more like the need to express something other, and then, something other again perhaps, and yet this otherness is related to the initial. It can sometimes even include ideas, I suspect, from the first. There is a connection. And there is a feeling, at the moment, which is nearly always forty-five minutes or so, that is one total period. Then I say "that is what I have to say at that stage." (Francis)

The questioning, searching and validating here demonstrates the client's ideology that the music therapy process emanates from an initial core which in turn affects, and relates to, the whole improvisation.

6.1.2.4. Sessions Twenty-Five to Thirty-Two.

As Francis's illness became more acute so the importance of music therapy in his life became more critical. During these later stages of our work together, due to the distance that Francis travelled, there were times when he was not well enough to attend. He also spent two weeks in the Mildmay Mission Hospital, Hackney, London, due to a severe weight loss, and chronic diarrhoea.

This stage was difficult for Francis physically, and emotionally. His bout of diarrhoea never left him, he found great difficulty in eating and digesting, and began to find walking a strain. Francis would identify these times of despair musically with such great accuracy that most sessions would end with extended periods of crying.

Francis realised the importance of his music and began to place great store in the fact that it would all be recorded, and thus would be available after his death. He began to see his improvisations as a testament of his life and death, and would whenever possible borrow the recording equipment in order to assimilate the work.

In session twenty-six, Francis endeavours to classify his feelings about music therapy :

"I have a feeling that this is almost like a testament. Its the only form of expression I have of a spiritual journey. Its the only time that I feel that I am living and communicating. The only time I feel that I am living the time I have left is when I'm improvising. All the rest of the time I'm wondering what the hell I'm doing. Time is a limited factor for me. When I,m doing these sessions with you, I'm actually living a moment, I'm actually living with somebody, and producing something, and revealing myself. It's very hard to find words which aren't terribly full of sociological overuse, you end up using cliched expressions, and I'm trying to put my finger on exactly what it is I'm trying to say. When I am improvising, I actually feel that I am saying something, and living, and its terribly important to me. One has to balance the understanding that nothing is that important, with the realisation that everything is that important, that is the paradox. That nothing lasts, and everything dies, and nothing can be the same again. The only reality is the moment you are actually living. But in a way I have this sort of inchoate feeling of leaving something behind which will say "this was a person, this was a flame, and there was this expression." I think its almost like that. I can't leave a written word and its almost a sense of wanting to leave some kind of form behind."
(Francis)

Francis now began to title most sessions, endeavouring to pin-point the essence of the improvisation through a single word or phrase :

Session twenty-six : Monolith.

Session twenty-eight : Despair.

Session twenty-nine : La fete des Morts.

Session thirty : Requiem.

Session thirty-two : For Colin.

Session thirty-one was unique as it consisted mainly of talking and verbal reflection. Issues of death and dying were discussed with great clarity and focus. Session thirty-two proved to be our last session together. By now Francis was extremely weak and we both knew it was only a matter of time before our sessions would be too difficult, physically, to continue. Even though neither of us was aware of the finality of this session, at the end of the improvisation Francis clearly portrayed musically his own death.

Two days after this session, Francis was admitted to the Middlesex Hospital. He died on January 17th, 1991.

6.1.3. The Music.

The musical content of the sessions was of paramount importance within the therapeutic process. The pre-requisite of an improvisational standard kept things balanced on a fine dividing-line between Art Improvisation and Therapeutic Improvisation :

"I don't want to produce beautiful sounds, I don't want to produce meaningful things. I want to sit down and to find that it actually flows, and means, and has

significance and value, and communicates with life. I want it to be part of the life flow. I cannot express myself however through an inferior musical medium, I consider the musical content as being an integral part of the process.” (Francis)

It is my conclusion as therapist that Francis saw his music as belonging to both categories, although the intensity and specificity of therapeutic intent betrayed a stronger connection with therapy than art. All the external validators saw the musical content as being a block, at certain points. The music therapist at one point states that she found it difficult to “detach the wonderful music from the therapeutic issues.”

Francis’s own past musical history, initially played a vital role in influencing his own musical dialogue, drawing on his great affinity with Liszt, Rachmaninov and Debussy. These influences during the sessions became more and more diluted as Francis endeavoured to find his own musical expression and style :

“I want my improvisations to be a part of the life flow, in a very spontaneous way, sort of throwing away the restrictions of playing or interpreting other peoples music, or being tied to any particular format or tradition, though of course one is working, even in one’s own immediate improvisation one is inevitably working in the living tradition. In a sense trying to express what is now, and not repeat what was in the past, or not necessarily searching for something in the future. But to say, “this is actually what I am saying”. I think its this kind of flow I want to feel. I want to be in touch with the living reality of expression at this very moment, therefore its music in 1991, and although in fact I’m unaware of what people are doing in 1991, because I was brought up on the classical tradition, I’ve never been greatly enamoured of Beethoven or Bach or Brahms. I always had a very

personal perception of my music, which was initially bound up very much with Liszt, more than any other composer, and Ravel and Debussy, and subsidiary forms. I discovered Prokofiev and liked his work too. That came closer, in a sense, to producing music which was of the day. I was trying to get in touch with myself as a living reality now, rather than as a fantasy, or a dream, or a nostalgia, or running away into something. I wanted to run into something, not away from something." (Francis)

6.1.3.1. Musical Awareness.

As this new more personal style of improvisation developed, Francis considered the fact that theoretical and technical expectations were no longer applicable to his improvisations :

" I have no idea of what I play in technical terms. I don't think "I want a major chord" I just play, this is the important thing. Looking back I can't say that this note was an E because I actually don't have what you might call the normal musician's perception of intervals. I don't think rationally. If you asked me to take an aural test I'd probably get most of them wrong. I don't have good recognition. But I find what I want, this is the interesting thing. I've got a feeling of what I want, and it comes out, its extraordinary. There is no conscious process, this is the amazing thing. I love it, this is what I dream of. And when something works musically and you smiled, and I think it's beautiful, it works, it's there, and it was something that just happened. I didn't say I need a major chord, I needed an open sound. I needed a sound, I needed to express something, and that is what came out, and it was right, and it was beautiful." (Francis)

6.1.3.2. Tonality. and Atonality.

During the sessions the harmonic emphasis shifted from strong tonality to a more fluid base lying mid-point between tonality and atonality. It was rare for Francis to shed completely a tonal infrastructure. When this occurred it was normally due to an intensity of therapeutic direction :

" I think tonality for me is the ability to use all the notes in different combinations, but subtly within the framework of a tonal system. Atonality is escaping entirely from that tonal system, which I don't think I often do. There is always some background of music in tonality. The background against which the music is created. The dissonance comes from within a tonal framework." (Francis)

6.1.3.3. Silences.

Theories and writings on silence can be explored at varying levels (Cage 1968, Castaneda 1987). From a psychoanalytic viewpoint Greenson (1967) discusses silence as :

"the most transparent and frequent form of resistance within psychoanalytic practice."

He further goes on to explain that silence can have various other meanings, including that of a repetition of a past event and as a reaction to the primal scene. Greenson's negative view of silence within psychotherapy is concluded with the view that :

"Silence is a resistance to the analysis and has to be handled as such."

Contradictory to this view, Cox (1978), when exploring the structure of the therapeutic process, discusses silence as an experience that may be far more eloquent and far-reaching than words :

"There is a sense in which the therapist may gently and quietly need to "follow" the patient, till he reaches a point when he is "invited in" to that area of experience."

Finally from a philosophical viewpoint Berendt (1988) states :

"If you want to experience sound, you first have to learn to experience silence."

Silences formed an integral part of all the improvisations. During the period of solos, Francis would divide the large improvisations with necessary resting silences. These would prove crucial in pointing to new directive avenues, the length and intensity being carefully graded. Greenson's theory of resistance is here clearly inappropriate.

"Silences are absolutely vital and shouldn't be shortened in any way. The actual length of the silence is the length of time which is necessary. It's the absorption period, and then I'm ready, or want to, or need to move to do something to continue that. But that moment of silence is an intrinsic part, an intrinsic part of what went before, and what is coming after, so its absolutely essential that it should remain the same." (Francis)

6.1.4. Conclusion.

In validating the above information, issues of counter-transference with regard to my own role as therapist must be discussed. To be an active part of such a musically and therapeutically dynamic process, raised issues for me on many levels. The Broad Spectrum (see 4.1.2.4.) certainly caused some concern, feelings of anger, irritation and of being manipulated, all needed to be addressed if I was to be effective. Francis, being a highly intelligent person, could often raise feelings in me of strained intellectual tension. His ability to know quite clearly what he needed and expected of me meant that at no time could I relax within the boundaries of the session. This placed pressure on my role, often manifested in feelings of frustration and annoyance. The Narrow Spectrum held similar problems. My own expectations of myself were constantly being challenged. Was I being tough enough, could I have been more musically and therapeutically confrontative, and was I quite sure that the direction of the sessions was clear to both the client and myself ? There were certainly feelings of compassion and of the enormous weight I carried in knowing that the sessions had both changed Francis's life and the ultimate importance he placed on their regularity. Over identification was an issue that I constantly faced during our work. I had fantasies of becoming HIV positive, and saw myself in the role of the client - how would I react if the roles were reversed, was I romanticising my own concepts of death and dying, and how much did I view Francis as a victim and scapegoat of society ?.

I faced many issues which demanded to be explored in great depth through my own psychotherapy. Francis forced a complete revaluation of what I thought music therapy was and how inflexible the current practice is within this country. If we take the premise that a music

therapist is only as good as the improvisational skills he/she has acquired, he showed me how little we understand about the dynamics of therapeutic improvisation. His verbal testaments give us some of the most illuminated and focussed perspectives of what it is to be a client in music therapy.

6.2. Stage Two. An Integral Investigation.

6.2.1. The Generative Cell.

During improvisation musical procedures can germinate from a small group of tones which form the criterion for the ensuing musical development. In this improvisation the tones are grouped into a single cell. The cell within the improvisations has been separated into the following sub-classifications :

The Pure Cell.

A representation of the cell in its correct order (e.g. A flat, G, E.). The cell may be extracted either as a single melodic line or as a melodic line contained within other textural devices.

The Inverted Cell.

A representation of the cell in its inverted order (e.g. E, G, A flat). The inverted cell may be extracted either as a single melodic line, or as a melodic line contained within other textural devices.

The Permuted Cell.

A single melodic line that must contain the three tones of the cell, in one single correlate. The composite cell may be extracted either as a single melodic line or as a melodic line contained within other textural devices.

The Harmonic Cell.

The cell as a basis for harmonic progression. To fulfil this criterion the harmonic constructions must be built purely on the three tones of the cell (e.g. A flat, E, G.).

The Concealed Cell.

This category covers all those instances where the cell is articulated as a pure, inverted, composite or harmonic expression, which does not fit into any of the above categories. This forms what might be termed as a subliminal delineation, incorporating subtle and minute handlings of the cell often dissembled within the overall structure.

The Transposed Cell.

A representation of the cell in a transposed format. The transposed cell must contain the intervals of the cell and be classified in either its pure, inverted, composite, harmonic or concealed classifications. E.g. Transposed/Inverted, Transposed/Concealed.

The generative cell has been identified for the whole improvisation within the bounds of the above criteria (see Figures Sixteen, Seventeen, Eighteen, Nineteen, Twenty and Twenty-One.). The classifications demonstrate the cell prevalence of each category and the importance of the cell in the structure of the improvisation. This information can be directly related to 6.2.2. and analysis one 6.3.

0:00-0:20 The Pure Cell. 1:02-1:06

0:24-0:38

1:06 1:21-1:36 1:36

2:30-2:45 2:58 4:19

5:36 5:56 6:37 9:20

9:42 10:49 12:30

12:46 14:51

15:49

15:58 16:03 16:13 17:55

18:44 19:06 20:12

20:23 21:20 21:53

22:10 24:35

This musical score is for a piece titled "The Pure Cell." It is written for two staves, likely representing different voices or instruments. The notation includes various musical symbols such as notes, rests, and bar lines. Time stamps are provided throughout the score, indicating specific moments in the piece. The key signature appears to be B-flat major or D minor, and the time signature is 4/4.

Figure Fifteen.

The Inverted Cell.

2:12 11:24 19:57 23:55

This musical score is for a piece titled "The Inverted Cell." It is written for two staves. The notation includes various musical symbols such as notes, rests, and bar lines. Time stamps are provided throughout the score, indicating specific moments in the piece. The key signature appears to be B-flat major or D minor, and the time signature is 4/4.

Figure Sixteen.

The Permuted Cell.



Figure Seventeen.

The Transposed Cell.



Figure Eighteen.

7:30

10:33

11:34

6:03

18:30

25:08

210.

THE CONCEALED CELL

A musical score for a piano piece titled "THE CONCEALED CELL". The score is written for piano (p) and consists of six systems of music, each with a treble and bass staff. The time signature is 4/4. The score is marked with various time signatures and measures, including 12:06, 2:35, 4:14, 4:34, 4:57, 7:50, 8:27, 8:34, 8:57, 9:26, 11:05, 11:05, 11:11, 11:14, 11:16, 11:37, 11:40, 11:48, 11:58, 12:03, and 12:11. The music features a variety of notes, rests, and dynamic markings, with some measures containing multiple notes in a single measure. The score is presented in a clear, legible format with standard musical notation.

Figure Twenty.

12:17 12:26 12:27

First system of musical notation, measures 12:17 to 12:27. It features a treble and bass staff with various musical notes, rests, and dynamic markings.

12:29 12:51 13:05 13:12

Second system of musical notation, measures 12:29 to 13:12. It continues the musical piece with similar notation and includes some chordal textures.

11:30 11:35

Third system of musical notation, measures 11:30 to 11:35. This system shows a change in the musical texture with more complex rhythmic patterns.

13:16 14:51

Fourth system of musical notation, measures 13:16 to 14:51. It includes a variety of note values and rests, with some measures containing multiple notes.

16:22 16:29 15:31 15:36

Fifth system of musical notation, measures 16:22 to 15:36. This system features more complex rhythmic patterns and some measures with multiple notes.

15:38 15:52 15:54

Sixth system of musical notation, measures 15:38 to 15:54. It concludes the page with a series of notes and rests, maintaining the musical style of the previous systems.

15:54 16:10

16:26 16:29 16:33 16:39

17:05 17:32 17:40

17:58 18:59 19:09

19:26 19:29 19:57 19:53

20:00 20:19 21:30 20:42

21:03 21:51 22:05

22:29 22:34 23:04

23:14 23:07 23:12 23:20

23:47 19:56 24:04

24:09

24:12 24:40

6.2.2. An Inventory or Musical Interrelations.

Investigating the improvisation in terms of a beginning, middle and end has been identified from a semiotic analytical approach to Classical music :

“This means framing the discussion in terms of a beginning-middle-ending paradigm, the argument being that there are specific attitudes to a work’s beginning, its middle, and its ending, and these strategies are an important clue to the dramatic character of Classical music.”

(Agawu 1991)

The conceptualisation of a Classical piece of music being contained within beginning, middle, and end parameters, is of significance in attempting to define and categorise elements of therapeutic meaning and musical outcome. within this improvisation.

The improvisation falls clearly into three parts :

- 1) Beginning - the material is stated and secured within concise periods of expression
- 2) Middle - the material is developed within extended periods of expression
- 3) End - the material is condensed towards an eventual recapitulation and ending.

A single cell (A flat, G, E.), provides the main developmental material for the whole improvisation (See Figures Sixteen to Twenty-One.). Broadly determined, the improvisation can be divided structurally into sections and sub-sections, which are heralded by either a ritardando or a pause.

The Beginning (0:00-7:23.).

Sub-section one - the cell is stated in single tones, twice, in the r.h. A melodic-line is improvised ending with a bass phrase, closing on E.

Sub-section two (0:50) - a dominant seventh chord is followed by a fast r.h. accompaniment (0:57) based on the cell inverted on E. A melodic-line descends, closing with an account, twice, of the pure cell at 1:02.

Sub-section three (1:06) - is comprised of octaves, reaching a climax at 1:21, falling away to three pure statements of the cell at 1:25.

Sub-section four (1:51) - at first is harmonically based on a C major chord first inversion. Prior to 2:06 the tones of the cell are superimposed within the harmonic framework, leading to a cadenza-like figure (2:12- 2:21). This sub-section ends with a displaced octave invention on the first two notes of the cell. (A flat, G) (2:21-2:30).

Sub-section five (2:30) - a variation of the cell is employed melodically, with a single bass-line accompaniment.

Sub-section six (2:48-3:11) - as in sub-section three, the music is improvised in octaves. It reaches a climax at 2:58 with a diminuendo towards the end of the phrase.

Sub-section seven (3:18-4:03) - is tonally centred around C major. Single tones on C lead to gentle accompaniment and melody, which is severed abruptly at 4:03.

Sub-section eight (4:03) - begins with a passage in two-part octaves leading to a cadenza-like configuration resting on a E major chord with an added seventh. The sub-section concludes with a repeat of the octave configuration (4:32-4:47), again based on the first two notes of the cell. A bridge passage (4:47-4:58) leads into sub-section nine.

Sub-section nine (4:58-5:32) - contains a melody and accompaniment (in duple time) followed by a tail-piece (5:17-5:32).

Sub-section ten (5:32-5:58) - again develops an accompaniment and melody (in compound time). The melodic line is clearly based on the cell.

Sub-section eleven (5:58-6:30) - juxtaposes inventions around the cell against a loose E major tonality.

Sub-section twelve (6:30-6:53) - a melody and accompaniment (in duple time).

Sub-section thirteen (6:53-7:23) - concludes this section with a repetition of the thematic schema already developed : a melody and accompaniment (in compound time) followed by a tail-piece, ending on E.

The Middle. (7:23-18:14)

Sub-section one (7:23-7:42) - is based on the pure cell.

Sub-section two (7:42-8:21) - is a two-part melodic invention in octaves, with a tail-piece leading to sub-section three.

Sub-section three (8:21-10:00) - begins with a two-part invention which develops into three parts (8:39), climaxing towards a measured single-line cadenza (8:53). At 9:06 the improvisation becomes more overtly pianistic, based on A flat, and at 9:20 there is a statement of the pure cell in the bass. 9:26-10:00, the improvisation freely develops in octaves, combining varying delineations of the cell.

Sub-section four (10:00-10:49) - consists of a similar schemata as found in section one (see 4:58-5:32) : a development section (10:00-10:26) followed by a tail-passage (10:30-10:49).

Sub-section five (10:49-11:24) - contains a basic development in two parts based on the cell.

Sub-section six (11:24-11:58) begins with a dotted-rhythm motif, moving through an extended cadenza (11:34-11:48) to a bridge-passage (11:48-11:58) centered on B flat and A.

Sub-section seven (11:58-12:33) - is an extended pianistic passage containing differing delineations of the cell, followed by a staccato bridge-passage (12:25-12:33).

Sub-section eight (12:33-12:51) - repeats the dotted-rhythm of sub-section six. An octave cadenza-passage descends into an extended development section.

Sub-section nine (12:51-13:27) - is based on rapid piano configurations, with inner melodic cells and motives.

Sub-section ten (13:27-14:07) - contains two musical ideas : the first (13:27-13:46) based on a two-part invention with descending intervals between hands, and the second (13:46-14:07) a series of similar motion descending chords.

Sub-section eleven - (14:07-14:30) consists of an accompaniment without a melody, based around E major. It converges chromatically to sub-section twelve.

Sub-section twelve (14:30-14:51) - is a development of the dotted rhythm motive based around A flat.

Sub-section thirteen (14:51-16:29) - is initially based on the pure cell in octaves (14:51-15:03). It then moves to a freer development which culminates in similar motion descending chords (15:28), through to a forceful and musically contained passage harmonically and melodically based on the cell (15:36 - 15:55). At 15:55 the texture clears (15:55-16:07) before a resumption of the previous chordal invention in contrary motion (16:07-16:29).

Sub-section fourteen (16:29-18:14) resumes exploration through an overtly pianistic style : a tremolando in the middle register with short motives and cells placed either side in the treble and bass (16:29-16:52). At 16:52 the texture becomes tighter with a constantly changing tremolando, and repeated middle C's. From 17:05-18:44, the schema is further developed, culminating in intensity at 7:58-18:44.

The End. (18:44-25:43)

After the preceding climax the music becomes more transparent. Sub-Section one (18:14-19:06) - is recitative in style.

Sub-section two (19:06-20:55) - is based loosely on the Spanish habanera rhythm (19:06-19:26). From 19:26-20:55 the music again becomes freer in style, ending with a repeat exploration of the habanera rhythm (20:39-20:55).

Sub-section three (20:55-22:19) - continues in a recitative-like vein in octaves (20:55-21:41), in two-parts (21:41-21:59) and then with simple chords (21:59-22:19).

Sub-section four (22:19-23:07) - initially explores similar motion phrases in four-parts, (22:19-22:37) followed by displaced octaves, sevenths and elevenths.

Sub-section five (23:07-25:08) - begins with a descending chordal configuration which develops through to 24:43, a clearer textured section in two and three parts. The rhythm becomes looser and the phrase climaxes at 24:04 with a free extended chromatic scale development. At 24:33-25:08 the music rotates firstly around the cell, and then focusses on A flat in octaves, significantly shifting to A natural and G natural at 24:57.

Sub-section six (25:08-25:43) - consists of three simple chords harmonically based on the cell, which concludes the improvisation.

6.3. Stage Three. Two Constituent Analyses.

Analysis one : 0:00 - 1:51

Analysis two : 12:51 - 14:07

6.3.1. Analysis One.

Francis stopped the tape at 0:19, after the first two phrases. A dialogue between myself and Francis followed :

Francis - "I remember that I felt in a very downward, what came was a very moving down. I was feeling hostile. It might not be the exact word, its a feeling of aggression. I was feeling the kind of dissatisfaction which comes from confusion perhaps, from a loss of identity. I think that when I don't have a strong sense of identity it can fall into some confusion, and then the confusion can make me feel hostile. I can start tilting at windmills and become full of negative and critical thoughts, which disturb one's balance. Certainly I remember this downward expression."

Therapist - "It was very difficult to listen to."

Francis - "Difficult in what sense ?"

Therapist - "Because the single tones were so carefully placed, I could actually feel....."

Francis - ".....the tension ?"

Therapist - "Absolutely"

Francis - "Quite disturbing"

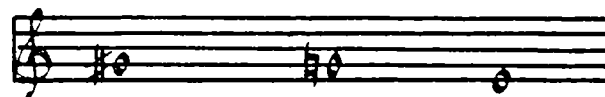
Therapist - "Perhaps disturbing is the wrong word, unsettling, rather than disturbing."

Francis - "That's good, because I think that was very much closer to what I was actually feeling. Its interesting that I was actually conveying that sense of being unsettled. The hostility I said which stems from a loss of identity, which perhaps is unsettled. I have felt a great lack in my life, in a sense that there is more likely to be a void or a quick-sand, where there should be firm support. I say to myself, "There is nowhere to go, there is no one to turn to." So there was no security, nothing you could latch onto and say, "I'm safe."

The opening two phrases contain the nucleus of musical and therapeutic meaning, both within the improvisation and the therapeutic process. Francis translated, through his assessment, a feeling of being unsettled and unsupported which, through a description of the intervals, conveys an accurate parallel between therapeutic intent and musical consequence (for explanation of computer spellings see 3.3.).



└ min 2nd ───┐ ┌── min 3rd ─┐
└─── dim 4th ───┘



└ Aug unison ───┐ ┌── min 3rd ─┐
└─── maj 3rd ───┘

The constant interval in both notational forms is the minor third, which is counteracted by the overall interval of the diminished fourth, or major third. In the case of number one this suggests an avoidance of tonality, and in number two an alternation between major and minor. The ambiguity of tonal centre can be clearly paralleled with the therapeutic aim of the improviser.

The difference in notational form, and accordingly conception of intervals, also displays a congruence that is contained within the whole of this thesis. That is to say, that every musical statement is ultimately open to interpretation of musical and therapeutic meaning. Within this chapter we find the greatest disparity of viewpoints, between the outside validators and the client. The complexities of collating such a divergence of material illuminates the problems of interpreting and classifying therapeutic improvisation within a methodological framework.

The opening phrase sets the framework for the whole of the improvisation :

"The improviser, by playing the single tones, was setting out his boundaries, within which he was going to improvise. Almost like Beethoven setting out the theme at the beginning of the Fifth Symphony. He is obviously familiar with musical form."

(Musician)

"I use improvisational techniques, if that is the right word, they are my hallmark, so that it's recognisable that it's Francis's format. I was very aware, as soon as I placed my fingers on the piano, that I wanted within the first few phrases to encapsulate the complete piece within these utterances, that the form of the

rest of the improvisation would rely completely on my first musical inventions."

(Francis)

Francis's improvisational schemata were an integral part of our work. His knowledge of musical form and structure enabled an immediate convergence of musical and therapeutic aims. The example contained within this analysis was not unique, but part of a refining process. By this time within the sessions his schematic procedure had become finely tuned, so that most improvisations would commence with the minimum deployment of notes.

The downward phrase is discussed :

"The downward tones of the initial phrases appear to be significant in that they are carefully graded and placed. The musical development that begins to take shape remains clearly within the confines of the first three tones. This translates a purpose of improvisational direction that is both clear and unambiguous in all aspects of musical content and construction." (Musician)

"The moving down of the opening music leaves me with a feeling of being unfinished, even though the phrase is obviously contained and concluded." (Music Therapist)

"The concept of musically moving down is an idea that is of great importance in my improvisations, especially when used within the opening phrases. The moving down holds the dying feeling, it in some way contains the vibrancy of the pain."

(Francis)

The downward phrase as an opening schemata was inherent within many of Francis's improvisations. It is significant that both the music therapist and Francis himself found the use of this device here as being directly related to issues of illness and dying.

The weighting and phrasing of the opening tones, were as important as their selection. Tones one and two, (A flat, G.) and tones three and four, (E repeated) can be grouped to give two sub-phrases within the phrase proper. The intensity with which both of these sub-phrases were articulated was subtle, and yet decisive in influencing the future therapeutic and musical direction of the improvisation. Francis was equally concerned with the quality of playing, as with the choice of notes and possible tonal centre. He had the ability to combine the intricacies of the immediate musical and therapeutic expression, whilst conceptualising the improvisation as a whole.

"He is squeezing the semitones for all they are worth." (Music Therapist)

The repetition of the last tone of the phrase, and its emphasis, gives a structural assumption that the tonal centre is E.

"Even from the opening notes, I can conclude that E is the core. From this point, even though I had no idea how the improvisation would develop, E was instinctively chosen to form the harmonic backbone of the whole piece." (Francis)

6.3.1.2 Consequences of the Cell

Francis immediately recognises his use of the cell :

"I think that I seem to be working a lot in unit structures. I think cell is a better expression. I have a tendency to work on cell ideas," (Francis)

This is echoed by the music therapist ;

"He improvises a cell-like figure, which keeps re-appearing." (Music Therapist)

The cell, within this section of the improvisation, is stated eleven times in its pure format (see Figure Fifteen) and once each in the composite (see Figure Seventeen), harmonic (see Figure Nineteen), and transposed classifications (see Figure Eighteen). This period contains the greatest density of statements of the pure cell within the whole improvisation.

Throughout all the observational data collated there is a disparity of meaning between Francis, the music therapist and the counsellor. This can be seen in a concentrated format through investigating the cell as an isolated component :

"He keeps on homing in on one figure. The cell keeps re-appearing. It feels in a way a little bit detached, as if he is holding something back. It feels as if there is not all of him behind it. He is improvising and it is his music, but he's holding something back, probably

for his own protection. There is something about him that he's not prepared to let people see yet."

(Music Therapist)

"By using the same group of notes, I get a sense of wanting to run away. There is a sense of conflict here which is very present."

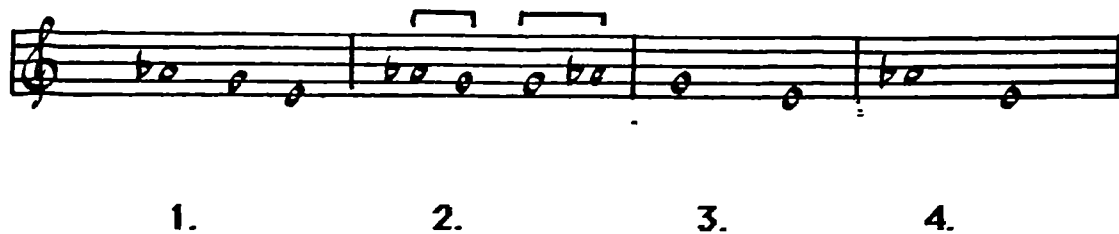
(Counsellor)

"The cell for me is the closest representation of how I am feeling. It is exposing in an indirect format. You don't express the thing by being the thing itself. You express it and communicate it by providing a structure, which in itself is supportive, even though you may be expressing things which are intrinsically not so. What I am getting at here is very much the feeling that all of this is being expressed, and held. It is all being held and contained within an artistic shape, which makes it possible for the listener to actually enter into it and fade away. I normally think in terms of, if you want to express boredom as an artistic feeling you can't do that by boring the audience. You have to fascinate them by your demonstration of boredom, but that they will understand the meaning of boredom. Listening to the cell figures, I suddenly got that kind of feeling."

(Francis)

In interpreting and contrasting the above information, the main nucleus deals with whether or not Francis was using the cell as a means of defense. His own evaluation was to explain the cell as a means to express something other than itself, and by doing so to define that expression as being less direct and more intricate. Do these comments reinforce the music therapist and counsellor's reservations that Francis was unable to face the conflicts of his situation or are the parameters, as Francis suggests, more complex than those of direct manifestation ?



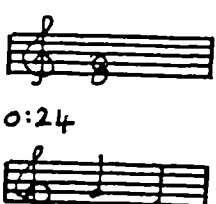
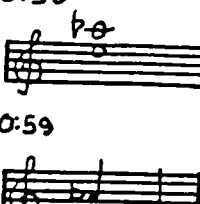

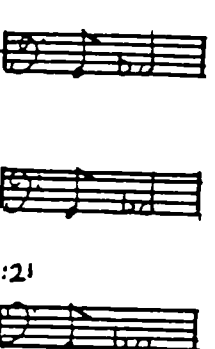



The cell is used derivatively in four combinations :



By classifying the cell derivatives from the four combinations above (see figure twenty-one), it is possible to reveal an initial concern with inventions of the pure cell. The repetition of the first two notes of the cell, four times within a single phrase, is also significant.

The rhythmic classification of cell derivatives (see figure twenty-two) has been categorised in terms of Meyer's rhythmic analysis. Initially by viewing Meyer's (1960) approach to rhythm we see tripartite basic units, of upbeats and downbeats, contained within the rhythmic cell. The association between upbeats and downbeats formed the theoretical base from which Meyer established his form of rhythmic analysis. He uses names from Greek prosody to classify five different rhythmic groups, the downbeat being indicated by — , and the upbeat by U .

iamb	U	—	
anapest	U	U	—
trochee	—	U	
dactyl	—	U	U
amphibrach	U	—	U

I	2	3	4
0:00	0:30	0:20	0:50
			
0:20	1:12	0:24	0:59
			
1:02	1:21		
			
1:21			
			
1:36			
			

Note. Brackets denote classifications contained within a single phrase.

Figure Twenty-One.

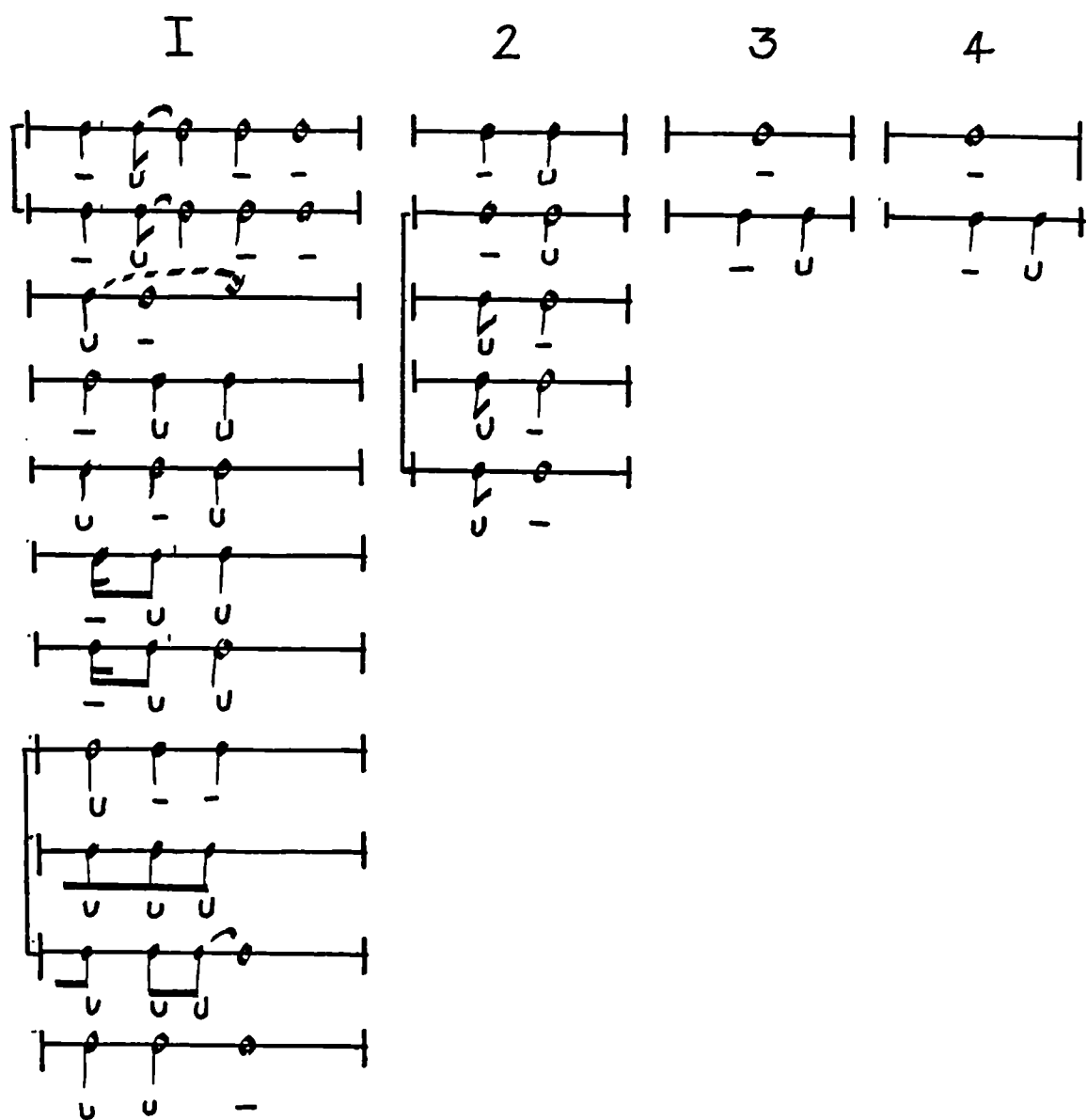


Figure Twenty-Two.

This analysis views each individual unit in terms of rhythmic stress. It demonstrates the prevalence of the dactyl classifications in derivative one, the iamb in derivative two, and the trochee in derivative three and four. It appears salient that Francis wished to stress predominantly the first note of the pure cell derivative, whereas when declaiming derivative two, the downbeat was placed on the second note.

It would appear that the rhythmic objectives of the cell within the opening schema contain fundamental patterns, that are as important as the choice of tones. Each phrase-length within the overall rhythmic framework is graded as an informed decision, with regard to the future direction of the cell development.

6.3.1.3. Ambiguity as a Therapeutic Improvisational Schema.

Throughout the whole of this sectional analysis, elements of ambiguity and uncertainty are established :

"I felt at the start of this improvisation that I had to bring in the element of uncertainty. I had to leave the door open somehow. I didn't want to say that it was definitely there, it's suggested, it's half open, it's glimpsed at. But as soon as you've caught it, it shies away again from the kind of feeling that is there."

(Francis)

This idea was communicated to the outside validators, in varying formats :

"The music appears to be very episodic. The improviser is having an idea, thinking a bit, and then is repeating or moving forward with musical ideas. This translates to me a musical feeling of indecisiveness, as if everything is being hinted at."

(Musician)

"The music is very intimate, a very strong feeling of introspection. I don't get an enormous feeling of space. It feels as though there is something more beneath the surface. I feel as though he is in some way avoiding things."

(Counsellor)



"I feel as though there are mixed messages going on. To start with I thought it sounded lonely, but on reflection I'm not sure what is going on. There is a great sense of him skirting around the real issues."

(Music Therapist)

The above comments can be paralleled with the analysis of therapeutic consequences of the cell (see 6.3.1.2.), in that it could be argued that Francis was using this improvisational form as a means of defence. The musician feels a sense of ideas being hinted at, the counsellor that there is more beneath the surface, and the music therapist has a general feeling of confusion with regard to the improviser's intent. The following analysis highlights this musical and therapeutic conflict, both in translation to the outside validators within the formal confines of the notated music, and for Francis's own self-analysis through this section of the therapeutic improvisation.

The structural form of this section can be examined to show its fundamental constructs (see figure twenty-three). Through investigation it is possible to discover an initial parity of invention. The three sub-sections (beginning, middle and end) each contain four inner sections, the weightings of which appear to be complementary in terms of musical content and size. The smaller less developmental statements are balanced by longer inventions of a more episodic kind.

There appears to be no developed constant pulse within this opening section. Phrases do adhere to regular rhythmic passages, but these do not normally last for long periods. Through the analysis of this section, it is possible to ascertain two main rhythmic components :

- 1) Four pulses of a generalised equal length. ()
- 2) A constant tri-partite rhythmic phrase. ()

Category one is utilised mainly in conjunction with the cell, with the exception of sub-section three (1:00) where it is used in an octave passage, and category two is utilised in rhythmically propelling the meter of the music towards a faster tempo. The generalised tempos, sub-sections one (beginning) and three (end) are slow in pulse, incorporating in the main, a steady crotchet tempo. Sub-section two (middle) contains from 0:48 - 0:53 a quadrupling of pulse, producing a faster tempo.

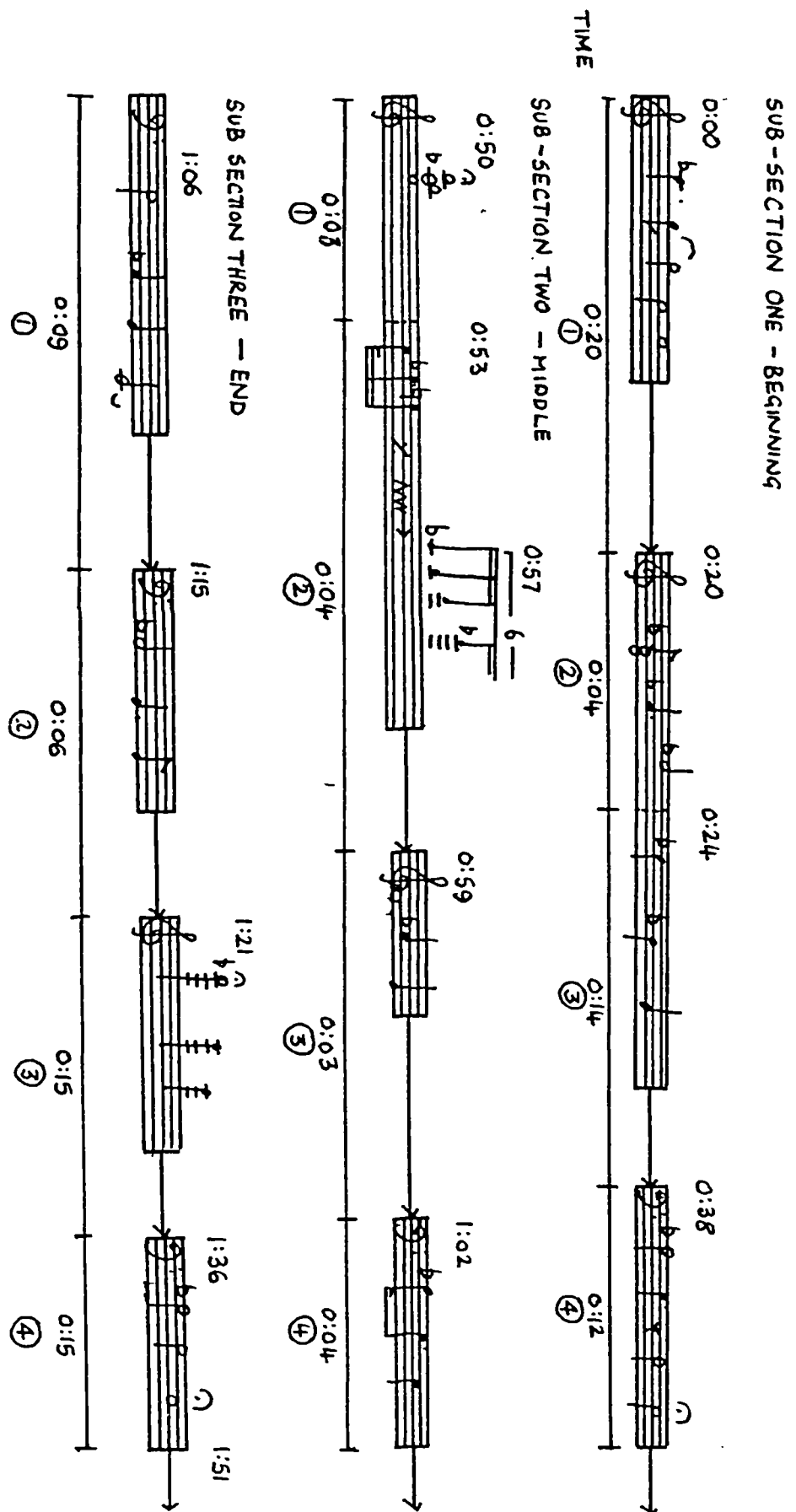


Figure Twenty-Three.

6.3.2. Analysis Two.

Analysis two is taken from sub-sections nine to ten of the middle section (12:51-14:07, see 6.2.2.). This passage will be analysed in three sections, a) the therapeutic improvisational peak (sub-section nine), b) the therapeutic improvisational after-peak (sub-section ten) and c) the peak relationship. The logic behind this analytical classification comes directly from the musician's comments :

"It would be interesting to compare the climax (12:51) with the section that comes after (13:27). How does this section affect the next passage and what is there about the relationship between the two that makes this climax so significant ?."
(Musician)

Sections a) and b) will be analysed independently, musically and therapeutically, endeavouring to extract the theoretical musical procedures highlighted from the observational data. Section c) will be analysed in a more integrated format, considering the musical and therapeutic aspects of the data collectively.

6.3.2.1. Sub-section Nine. The Therapeutic Improvisational Peak.

At this point within the improvisation Francis together with the three external validators commented :

" The whole of this passage is breaking up. Different things are emerging and then getting lost and going
235.

away. "Don't hold onto it let it go", breaking up and yet in a unified field. Although there is the feeling of bottomlessness or of instability, the actual artistic production holds you." (Francis)

"This section is extraordinary, because of its sense of freedom and exploration. Totally in contrast to what has happened before, there is an almost full letting go with a completely new technique. This is by far the most important episode yet. Because the defences are now down there wasn't the sense of self-protection, there was much more a sense of freedom and self-exploration. Of very deep pain and searching. An extraordinary passage in all ways." (Counsellor)

"This feels quite different, as though we are getting to the business more. It also feels a lot more creative, it feels less like an improvisation and more like a statement about himself, it's more direct. There's more going on musically, but it feels more immediate, as though he has stopped thinking. It feels as though his head has gone and that this is now more from the inside." (Music Therapist)

"This passage is musically more sustained and powerful than anything that has gone before. The tonal base takes it's root from E, the last note of the opening cell, with inferences of E major triads alongside the more ambiguous tones of the cell itself. The rhythmic pulse is fast and regular in the right-hand, with more melodically informed phrases in the left-hand, providing an overall balance for the rapid configurations in the bass. (Musician)

The prevailing observation that there was a fuller letting go of self-expression is significant. The peak was felt to be critical therapeutically and musically, and constitutes the only point within the validator's data where there is a general agreement of communication.

By viewing sub-section nine in its skeleton musical format (see figure twenty-four), and then by dividing the passage into smaller sub-components (1-14), it is possible to explore the view of the outside validators that this passage is spontaneous, alongside Francis's own interpretation that the expression is contained within the boundaries of the whole improvisation.

The structure, a series of almost unending rapid configurations in the r.h., whilst being free in overall design does have an underlying musical shape. Components one-six are influenced by the fast tempo and the fluctuation of major and minor. Components seven and nine, two arpeggioc figures, sandwich a return to the fast section with one important difference, a statement of the cell underneath the rapid figure (l.h.). Components ten-twelve develop a three-note bass cell. This is developed into components thirteen and fourteen, a two note cell (played two and a half times) in the r.h., with the rapid figure now being moved to the l.h.

By re-examining the initial investigation of the cell (see 6.3.1.1.), and the conclusion contained within the second interpretation of notational format that there is an alternation between E major and E minor, we find in this passage a clear reference to this procedure.

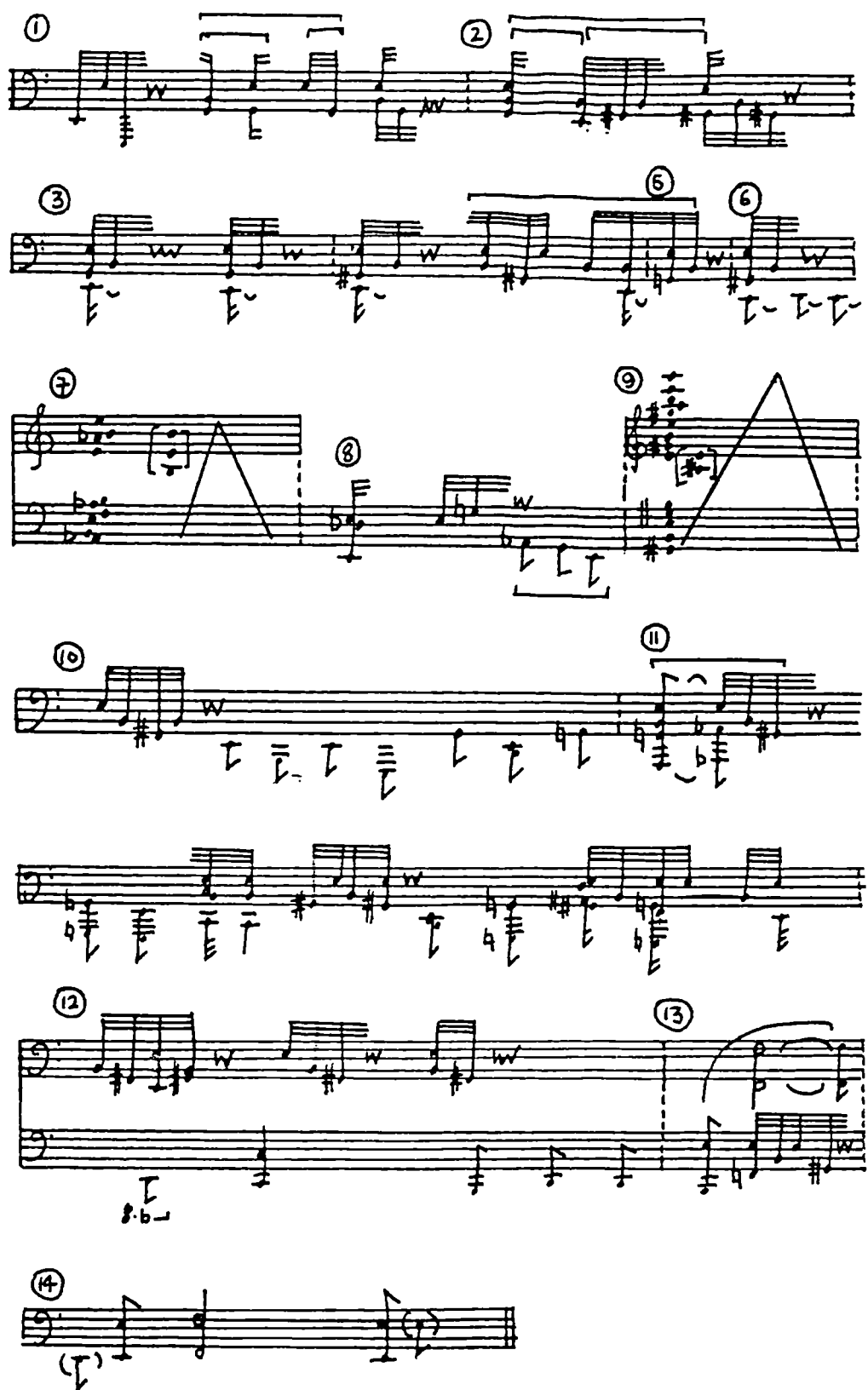


Figure Twenty-Four.

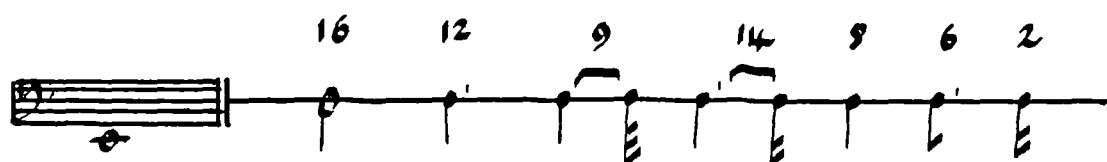
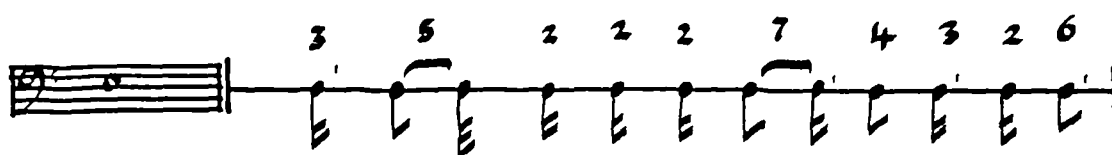


The cell as an underlying melodic motive, demonstrates the importance of its use in a concealed format. (see figure twenty, p 211.)



The passage (cells 1-10) is based on three accounts of the pure cell interspersed with three two-note cell derivatives (cells 1-6), followed by four independent two-note cells (cells 7-10). The last statement of the two-note cell is severed in mid-stream.

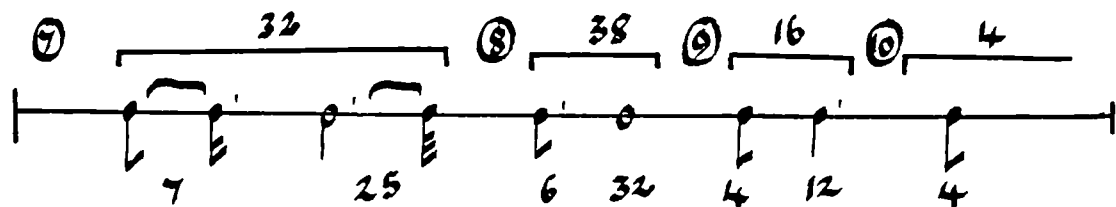
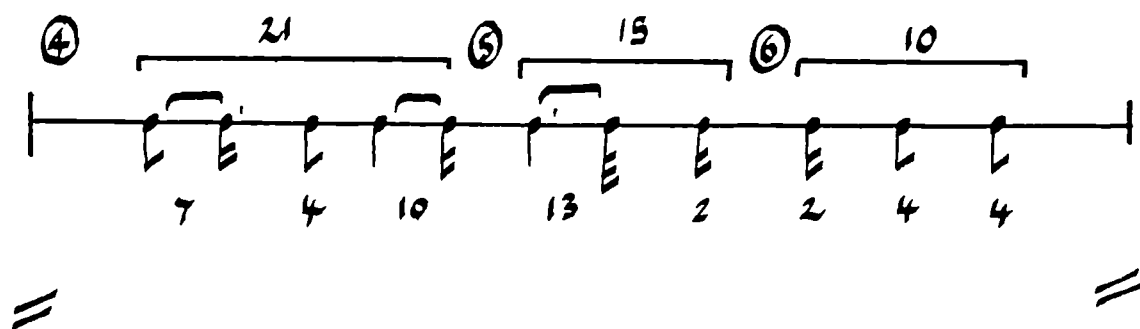
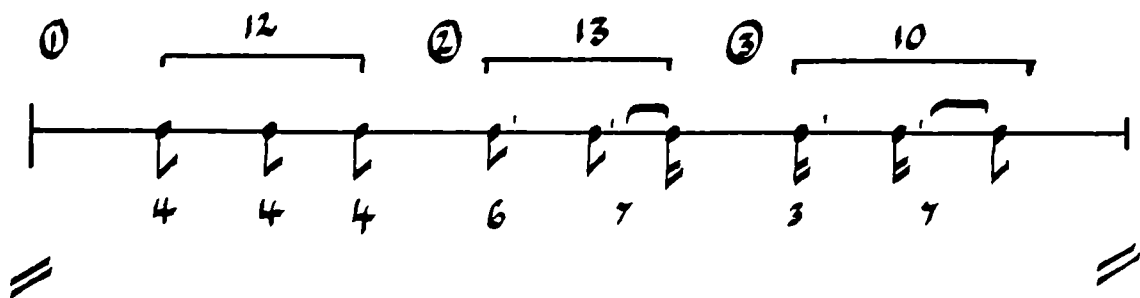
The rhythmic flow of this section has no precise meter. Components one to six are rhythmically directed from two phrases of repeated E's.



Components four - six



It appears that any inclination towards a constant pulse is interspersed with odd-numbered rhythmic groupings. The irregular rhythmic nature of this whole passage can be further highlighted by a rhythmic examination of the melodic cell.



6.3.2.2. Sub-section Ten. The Therapeutic Improvisational After Peak.

After the complexities of sub-section nine, sub-section ten is simple in format. The contrast in musical expression raised differing opinions from Francis and the outside validators:

"This development has been going through, and has come to prominence at this point where there is a simple two-part theme. There is all that darkness and then just one brief moment when the clouds actually roll away. I just fell for one brief moment into the most simplest form of harmonic clarity, but for a brief moment only." (Francis)

"After that messy section we now hear music of utmost clarity, although to me it doesn't convey other than again a sense of detachment." (Music Therapist)

"This music is far more reflective than what has just gone before. The falling treble phrase was carefully placed in terms of musical expression. The freer section just improvised has allowed what now feels like a more accurate representation of his "true-self". (Counsellor)

"After the extended rapid section we discover a passage that is simpler in musical design. The two-part trombone-like phrases (13:27) in thirds and fourths lead to a descending scale (13:46). The scale is initially based around fourths in the right-hand, with a repeated B in the left-hand. This becomes more chromatic in content (13:56) leading to a resolution in E minor (14:06). (Musician)

There was general agreement that this passage, in contrast to the last section, is simple and clear in design. The music therapist and counsellor differ in their assessments ; the counsellor considering this music to be a more accurate representation of Francis's "true-self", whilst the music therapist is still not convinced that there is a true portrayal of expression. Francis conceptualises this section as a brief moment of clarity, the musician concluding that the descending scale (13:46) was significant.

Sub-section ten can structurally be divided into two parts (13:27-13:43, and 13:46-14:07), with a bridge passage (13:43-13:46) bonding both halves. The simplicity of form is direct, a descending two-part invention, followed by an extended similar-motion downward phrase.


Harmonically 13:27-13:46 is simple. At 13:27 the phrase in thirds appears to be based on chords four to one in C major. This throws the harmonic implication of the final stages of the peak passage which, through the repeated E, suggests a conclusion of E major/minor. Immediately after this phrase, the C major implied tonality is destroyed by a concealed statement of the cell. The top-line of the first phrase is repeated, with a lower-line in fourths. The concealed cell is repeated five times (13:35-13:43) with a descending phrase placed on the last note of the phrase, beginning on the fourth and moving step-wise down until the concluding E.

In the first half of sub-section ten the cell is employed six times in its concealed format (see figure twenty, p 211.) At 13:30 it is used divisionally, breaking the white-note tonality suggested by 13:27 and then is developed in its own right with a step-wise melody descending underneath. In the second half it is interesting to note that a pure cell

statement (13:56) in the lower of the three parts is used for the last three tones at exactly mid-point in the descending scale. This heralds a shift from the established white-note tonality to a more chromatic invention.

At 13:27, a stable rhythmic figure is announced :

() This is interspersed with a triplet figure,

() which after a repeat of the first phrase, is developed leading to five constant pulses at 13:43 linking the two halves of this passage. The descending scale (13:46) is contained rhythmically within a regular quaver pulse. It begins with a dotted / appoggiatura figure, leading to regular aligned chords which are concluded with a ritardando and pause at 14:06.

6.3.2.3. Peak Relationships.

What is it possible to deduce from studying the therapeutic improvisational peak and after-peak which will illuminate Francis's procedures and the impressions gained from the external validators ?

The defining of what is termed as "Elements of Communication" (see 1.5.2.) within the context of this investigation, do appear to have great significance in the future events and direction of the improvisation, even though the music therapist is musically passive (see 6.1.2.3.). The counsellor and music therapist agree on this from differing perspectives :

"It is very interesting to see this section in terms of the true-self and false-self. The improviser was able to access his true-self through the freer passage. This must have been a very moving experience within the whole framework to have allowed himself the freedom to let go of his false-self. It is interesting to see this form of expression as a musical technique and the sense of freedom that it has." (Counsellor)

The fact that this passage in itself could be interpreted as providing a means to accessing Francis's true-self, is crucial in validating the preceeding analysis and its subsequent relationship.

"Its amazing when you think about what is happening. The notes seemed right, and the way he played them, but the feeling didn't seem to be there. What therefore makes this passage meaningful ?. To him it must have been significant, but to me it wasn't and I don't know how you define that." (Music Therapist)

The consistency felt by the music therapist that the intensity of musical and therapeutic content at this point had not been communicated is significant in that it was a view not expressed by the other validators. As the music therapist suggests, there is no way of

defining a standard methodology of communication between the improviser's intent, and the validators' interpretation, which will in itself prove conclusive in terms of musical and therapeutic significance.

The conclusion that the peak was freer and less clearly defined in terms of structural schemata, compared with the after-peak which adhered to a simpler and more controlled format, leads to questions regarding the therapeutic importance of improvising in less musically coherent shapes and the effect this has on the structure and value of the ensuing therapeutic and musical development.

What structural devices were used to attain the improvisational peak and after-peak, and how can they be explained in terms of the therapeutic relationship ?. The simplicity of the peak, structurally, is concealed within the complexities of musical language. The after-peak, in comparison, is simple in form and content. Possible conclusions take their basis from the fact that both passages are contained within an overall structure of straightforward divisions.

Theoretically, the harmonic relationship is loose. The major/minor axis and the descending scale passages emanate from different harmonic sources. This difference in harmonic expression can be directly compared with the validators' interpretations, all of whom view each passage as being independent and yet connected. Their impression would suggest that the harmonic content required separate and distinct formal procedures.

The cell relationship is more complex. It appears at this point within the improvisation that the cell identification has become less direct. In the peak passage the cell is used primarily in its pure format, these statements being concealed within the overall texture of the music. In the after-peak passage it is used during a) to diffuse any implied harmonic direction and during b) to herald the change from the white-note tonality to chromaticism.

In similarity with the harmonic relationship, the peak and after-peak are different in terms of rhythmic content. In the peak, whilst there is a consistency of demi-semiquaver patterning, the overall form is arrhythmic due to the inconsistency of pulse in the l.h.. In contrast the after-peak is clear in its rhythmic direction and is generally regular.

6.4. Evaluation and Synthesis.

It has been clearly identified throughout this chapter that the cell forms the main musical and therapeutic core of expression. By considering the passages aurally it is possible to raise certain questions : the peak passage initially appears to have discarded the cell, its re-appearance at 13:05 in the lower bass is projected clearly through the dense texture. Its use in the after-peak passage is evident, due to the simplicity of language. Even so its emergence is ambiguous,

jeopardising any feeling of musical consistency. Is the cell therefore used as a defence mechanism, as so strongly expressed by the music therapist and counsellor, or is it incorporated, as theoretical and aural analysis would seem to suggest, as a means on the one hand to contain the musical procedures and, on the other, to contradict any sense of harmonic clarity ? The importance of the cell in directing the improvisational schema is paramount in bridging the gap between the therapeutic and musical boundaries. The cell-nucleus as a developing procedure within this sectional analysis would seem to indicate that as a therapeutic improvisational process, it holds elements of both constraint and freedom.

That Francis felt his improvisations to be a testament of his living with AIDS can be clearly validated throughout this chapter. The question that arises is, how accurately Francis's feelings are translated to the external validators via the recordings, and thus how valid are the findings in themselves, taking this variable into account. The problems arise in combining the comments made by Francis himself together with my own subjective views alongside comments by the external validators which arise from an experience which is ultimately, second-hand.

Francis always projected to me, the therapist, through his improvisations and verbal dialogue, a feeling of being unsupported :

"Quite often, my improvisations are a reaction to an immediate sense of loss and frustration, and my own fantasies which come from my own feelings of loss or deprivation, or having to deal with ending. Having to deal with the destructiveness of others. This has been a problem in my life, it's dealing with what I have felt to be lack of support for my own individuality. Support

**for me as an individual, as a person, as a value to be expressed both in my own family and in society.”
(Francis session twenty-eight)**

The music therapist, found the communication of specific feelings within the improvisation unconvincing :

“I just felt as though he was playing all those busy phrases, and I was sitting here while it was going on, and I was thinking “this should be conveying something panicky”, but it wasn’t, there was still something missing. I feel as though it’s not a direct communication of what he is feeling, or rather that it is, and he has only reached a certain point within it. The notes where right, but the meaning behind them wasn’t. It comes down to, “ what is it that makes it meaningful, and what is it that doesn’t.”, and I don’t know how you define that.”

(Music therapist)

The counsellor focuses on the defense of the pain :

“ Even when the feelings are directly in the music, I have a sense that they are being protected, that actually the real pain is being protected in some sense. There is a protection of the pain which at times feels very severe, and is only reaching certain parts of it, and no more.” (Counsellor)

This discrepancy is further complicated by the fact that Francis consciously would communicate non-directly :

"You don't express the thing by being the thing itself. You express it and communicate it by providing a structure, which in itself is supportive, even though you may be expressing things which are intrinsically not so." (Francis)

Could the discrepancies with the external validators have come mainly from the fact that they were listening to a recording or was there an element within the music which were so personal to the client and therapist that it did not translate accurately to the outside listener ?.

Referential or programmatic improvisation (Bruscia 1987) in terms of music therapy, is when the music is organised in reference to something other than itself. From a musicological viewpoint the possible translation and narration of Francis's musical and therapeutic associations, can be seen to be more complex and debatable. Nattiez (1990) states that in music, connections are situated at the level of discourse :

"Listening to Till Eulenspiegel, and with the help of the title, I can readily agree that it concerns the life and death of a character. I certainly hear that he moves, jumps, etc. But what exactly does he do ?"

So what was Francis actually doing in this improvisation that caused such discrepancy in related narrativity ? Through interpretation of his own words and music I would suggest that he was representing a semblance of narration through multi-layered means, sometimes direct and at other times through a complex metamorphosis of musical and therapeutic forms. This convolution of evocation addressed at both direct and indirect musical and therapeutic levels, leads to an intricacy of meaning and content. On one level Francis was concerned only with the improvisation through the boundaries of the session. On another level he was acutely aware of the potential for his improvisations to communicate further afield, through the availability of recordings and via this research project. Francis's communicative narrative in therapeutic improvisation can therefore be placed at a circuitous level.

As the music therapist involved within the sessions, I found that the solo improvisations in particular were specific in portraying musically Francis's psychological state. Through the analyses, it has been shown how meticulously Francis graded his musical expression and how crucial each phrase was in depicting his feelings. That his refined musical ability developed during the therapeutic process is clearly portrayed through the whole of this chapter.

"It's too much to talk about. What can you say ? So much pain. It's a kind of combination of pain and distress, and anger, and acceptance and refusal to be resigned about it. So much sense of purpose, determination. So powerful. I don't know where I get the energy from. I don't feel ill afterwards. I always feel better, and that's extraordinary "
(Francis. session twenty-five) (Lee, 1991)

Part Three.

Chapter Seven.

Review and Findings.

7.1. Introduction.

Evaluation of the efficacy of therapeutic improvisation for people living with the virus HIV and AIDS in terms of musical content and therapeutic outcome, can be undertaken at various levels. Each constituent factor will be addressed throughout this chapter - from the broader issues perceived from the general commonalities of stages one and two through to the more specific findings made through the core analyses of stage three and the testing of the hypotheses. Further to this, personal evaluations of the project as a whole will be made. The material will be discussed on two levels ; the perceivable - those conclusions that relate to the actuality of information (objective), and the conjectural - those conclusions that relate to the interpretation of subjective information. The chapter will conclude with certain proposed possibilities for further research.

The index of music therapy considerations (see 1.5.2.) and characteristics of improvisation (see 1.5.3.), outlined in chapter one, formed the main avenues of improvisational procedure for my work as a music therapist. These categories were crucial in determining certain boundaries of the therapeutic practice and possible approaches to musical expression. Whilst not authoritative in content, they did affect the therapeutic process and thus the findings of this project. The concept, that certain styles of improvisational playing were

evolved by the client and therapist, a) as a therapeutic relationship (Eddie and Charles), and b) as an individual (Francis), can be studied from the general findings of the three clients investigated. Charles, though limited in musical ability, formulated an improvisational style that based itself upon certain modes and scales which, broadly speaking, fell into simple structural divisions of two contrasting sections. Eddie's musical procedure was more complex, avoiding tonality wherever possible and structurally evolving through small sections of divergent textural devices. Francis's solo improvisations were diaphanous and limited to the smallest expression of musical components.

7.2. Results.

The hypotheses of the project (see page nineteen) acted as an anchor in formulating some fundamental suppositions that were deduced from my experience as a music therapist working alongside people living with the virus HIV and AIDS prior to the inception of, and during, the research project itself. The results take their foundation from the information discovered solely within the bounds of the project.

Note. Further work in oncology undertaken by the author since the completion of this research, would seem to suggest that the issues and results raised in this work are applicable for all people living with a life-threatening illness.

7.2.1. Hypothesis One. Musical Representation and Therapeutic Development.

Eddie was aware of the benefits of relating the musical to the therapeutic processes (4.1.2.1. see aims) early within the therapeutic alliance. He also considered the conscious act of technique in relation to catharsism. (4.1.2.2. see d.) Within the constituent analyses (4.3.) it is possible to find information that supports this hypothesis :

<u>Chapter Subdivision</u>	<u>Page</u>	<u>Extract Details</u>
4.3.1.1.	113	Eddie
4.3.1.3.	123	Eddie/Counsellor
4.3.1.4.	126	Music Therapist
4.3.2.1.	128	Eddie/Music Therapist
4.3.2.2.	129	Counsellor
4.3.2.3.	134	Eddie

Table 7.1.

Charles in his initial correspondence (5.1.2.1.) states clearly that the music was an accurate transcription of his feelings at the time. The formulae of sessions (5.1.2.2.) also demonstrates a need for the connection between musical and therapeutic representation. Throughout the constituent analyses (5.3.) there is available material to support hypothesis one :

<u>Chapter Subdivision</u>	<u>Page</u>	<u>Extract Details</u>
5.3.1.1.	160 - 161	Counsellor
5.3.2.	171	Music Therapist
5.3.2.2.	177	Charles/Counsellor

Table 7.2.

The information gathered from Francis in the idiosyncratic description (6.1.) whilst not specifying a direct connection between the therapeutic intent and musical outcome, does discuss both aspects in direct terms of the other. It could be suggested that this is the most directly applicable evidence to support the hypothesis. In the constituent analyses (6.3.) therapeutic avenues are discussed in direct relation to the musical processes :

<u>Chapter Subdivision</u>	<u>Page</u>	<u>Extract Details</u>
6.3.1.	220	Francis
6.3.1.	222	Francis
6.3.1.2.	224	Counsellor/ Music Therapist
6.3.2.1.	233	Counsellor/Musician
6.3.2.3.	244	Counsellor

Table 7.3.

The above findings would seem to support the hypothesis that ; in therapeutic improvisation there is a direct link between musical representation and therapeutic outcome.

7.2.2. Hypothesis Two. Importance of Musical Components.

There is at present no current information in the music therapy literature that deals with the possible importance of musical components in therapeutic improvisation. Music is most commonly referred to as the intermediary object through which the therapeutic process passes. Thus the quality and content of the music itself often takes secondary place to the therapeutic aims.

It was the design of this hypothesis to investigate certain improvisations in terms of musical and therapeutic process and outcome. This concept was researched both in terms of the musical/therapeutic relationship and the individual within the relationship. Whilst the aesthetic quality of the improvisations was not taken as a pre-requisite for inclusion in the project, all three clients involved commented on the need for the therapist's consideration of musical content and aesthetic status :

"When we improvise together in the sessions the expertise of your musical input is vital. I expect your musical inventions to be of the highest order, otherwise I would not have been prepared to travel personally. I remember testing you musically when we first started working together ; could you match and meet my quite often intricate musical inventions ? I needed that aesthetic musical content before I was ready to move on." (Francis)

**"I love it when your music is good, it enables me to grow. I depend upon the quality and beauty of your music to say the things I can't say musically."
(Charles)**

"The music you provide for me in the sessions is important. Whilst I don't always want beautiful music, there are times when I need you to support me musically through more complex structures than I can manage. They give me the opportunity to express my feelings at a much higher level. These times to me contain elements of beauty." (Eddie)

At an initial level the above comments would seem to suggest that when working with people living with the virus HIV and AIDS great consideration should be made towards the intricacies and quality of the musical components. In terms of the three core chapters (4,5, and 6) it can be concluded that much was discovered about the therapeutic process via the investigation of musical and therapeutic components. Each proved to be equally substantial in illuminating more indepth aspects of the music therapy development. The findings of this hypothesis would seem to suggest that when investigating the processes of music therapy with people living with the virus HIV and AIDS, equal weight should be given to the musical and therapeutic components.

7.2.3. Hypothesis Three. Generative Musical Themes.

The full transcriptions of the three improvisations (see volume two) provide an overall aural and notational perspective of the complete musical executions. The distinctiveness of each improvisation can be attributed to the capacity for hierarchical expression through therapeutic improvisation : e.g. the pain expressed

directly through perseverative playing (Charles) contrasting with the circumlocutory representation of pain via complex manifestations of the generative cell (Francis). These differential forms of expression further appear to be contained within certain commonalities of musical themes.

Through the analyses of each of the three clients, the main area of congruence deals with what is termed the generative cell (see 6.2.1. and 4.2.1.) and the seed motif (see 5.3.1.). Eddie utilised a dual cell format of i) single repeated notes and ii) a small differing group of repeated notes. Charles' perseverative playing, which could be classed as a cell in itself, is contrasted by three thematic seeds improvised by (T) P1. Francis's incorporation of the cell forms a more integral part of the whole improvisation and is complex in format and design. It forms the complete structure of the improvisation and provides strict boundaries within which the rest of the music is contained.

Carter (1990) was the first person to identify the significance of a particular group of notes in music therapy :

"In the early stages of the work a small melodic phrase emerges which comes to assume a significance which is not immediately noticeable when it is first played. It is often discovered on reflection, for it is not until I have given sufficient time and thought to the musical process that the importance of what has been sounded becomes apparent. This small melodic phrase comes to be heard as the Leitmotif of the individual."

She further goes on to say :

"In all cases I was to find that "Leitmotif", as it came to be called, embodied either the nature of the presenting problem, or to be a realisation in sound of an aspect of personhood by which the individual waited to be recognised."

The above interpretation deals with aspects that are at the heart of this project. The cell and seed which arise throughout the analyses, form the most crucial and potent musical representation of the association between therapeutic improvisation and expression of the client's psychological state. Whilst the above study confines itself to the melodic "Leitmotif", the findings of this project would seem to suggest that this concept of the importance of a small group of notes transfers further into areas of harmony, rhythm, texture and overall structure. In the case of Eddie and Charles the significance of the cell/seed did not become apparent until the indepth analyses. Francis's incorporation of the cell however was instantly unmistakable, the extent of its contribution to the musical make-up not being fully ascertained until a cell-dissection was made. Each client's use of the cell/seed was unique to his own personal growth within the improvisation and the music therapy process as a whole. What is common to each is the crucial nature of the cell/seed expression in transferring into a musical paradigm, elements connected with living with a life-threatening illness.

The concept that a small group of notes provides the basis for a conscious and/or subconscious containment of specific and/or global expressions of therapeutic and musical meaning, would seem to suggest that therapeutic improvisation originates from a core which develops through various stages, towards a complete unification of musical and

therapeutic ideals. Whilst each client's share in this process appeared different, the exploration of self-expression appeared to travel generally along the same route.

7.2.4. Hypothesis Four. Musical Preference and Culture.

Each of three clients discussed within this thesis, plus myself as therapist, had clearly identifiable musical influences that could potentially have affected certain aspects of the single improvisation analysed. Eddie found that the improvisation group AMM (see 4.1.1.) influenced his musical thinking, Francis reflected back on his love of Liszt, Ravel, Debussy and Prokofiev (see 6.1.3.) and Charles found that the middle-eastern mode and Spanish idiom (see 5.1.3.) became central to his musical expression. My own musical components on one level were guided by the needs of the client and on another level influenced by my own culture and preferences as a musician (Tippett, Finzi, Bach and Zappa).

note. These levels were able to survive both separately and together depending on the musical and therapeutic variables of the improvisation.

Three examples have been chosen to further corroborate the above information. They consist of scored comparative musical influences. The notated improvisations (see volume two) have been placed alongside the pre-composed music and notated scales :

note. Due to the fact that the improvisation group AMM do not have available notated transcriptions of their improvisations, a direct comparison with Eddie's improvisational influences is available through aural means only.

1. Charles.

Score 6:27 - 6:32.

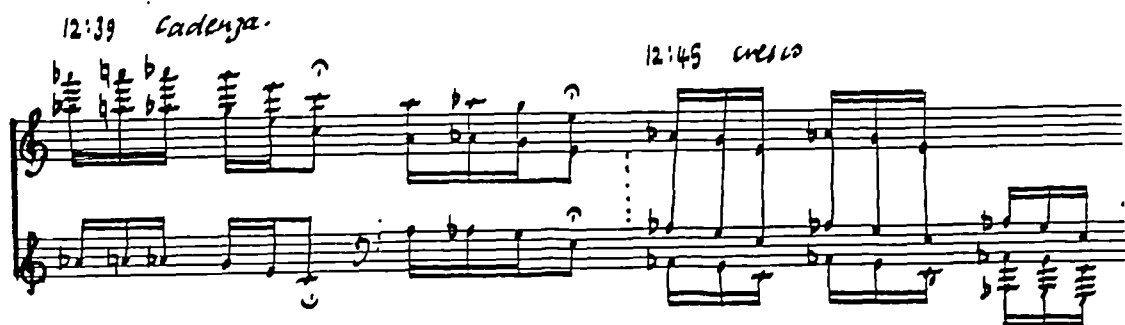
Handwritten musical score for a piece titled "1. Charles." The score is for a piano and is marked "Score 6:27 - 6:32." The notation is in treble and bass clefs, with a key signature of one sharp (F#). The tempo is marked "Bve" (Breve). The score includes a "w/ten pedal." instruction. The notation features various rhythmic values, including eighth and sixteenth notes, and rests, with some notes grouped by brackets. The score is written on a system of five staves, with the first two staves in treble clef and the last three in bass clef. The notation is handwritten and includes various markings such as "Bve", "w/ten pedal.", and "5:27".

Middle-Eastern Mode.

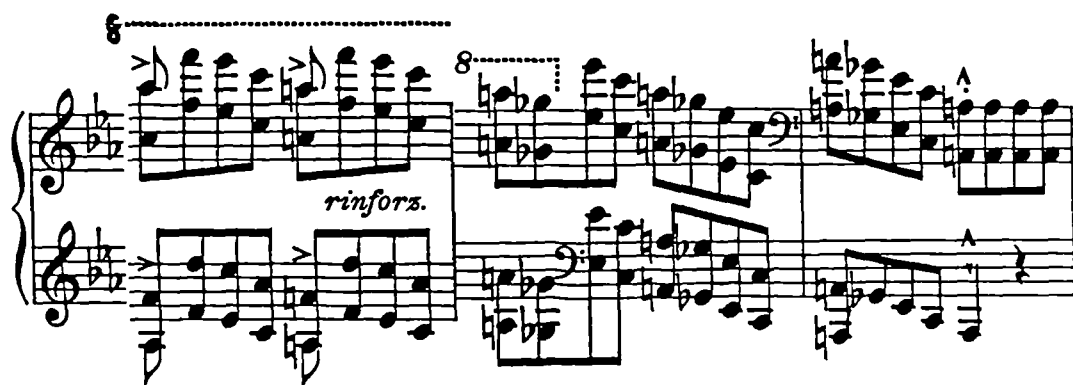
Handwritten musical notation for a "Middle-Eastern Mode." The notation is in treble clef, with a key signature of one sharp (F#). The melody consists of a sequence of notes: G4, A4, B4, C5, B4, A4, G4, F#4, E4, D4, C4. The notes are written on a single staff.

Francis.

Score 12:39 - 12:51.



Liszt. Sonata in B minor. Bars 80 - 82. (Edition Peters)



Therapist.

Score. Eddie 1:45.

1:45 *cresc poco a poco* *poco accel.*

Tippett. King Priam 422-433. (Edition Schott)

News — of Hec — tor's shock-ing death — spreads
Hek — tor tot," so gehi's durch Tro — ja

Pft.

News — of Hec — tor's shock-ing death — spreads
Hek — tor tot," so gehi's durch Tro — ja

f sub. martellato

If we conclude that the musical preference and culture of both client and therapist can have a direct effect upon the musical components incorporated within therapeutic improvisation, then what is the potential for this hypothesis to effect the therapeutic outcome? If the musical influences of the improvisation are highlighted and incorporated within the therapeutic procedure then the actual therapeutic benefits can be either, or both, positive and negative.

Francis struggled with his own musical influences within the therapeutic framework. He realised the potential for their necessary inclusion within the improvisations but also acknowledged the potential they might have to block his therapeutic direction. By the conclusion of our sessions his improvisations became a much clearer representation of his own musical personality whilst accepting the core from which his expression originated. Eddie and Charles utilised their musical influences at a much more fundamental and subconscious level. They did not wish to actualise the musical origins of their improvisations beyond their basic recognition. The effects on the therapeutic outcome taken from the above conceptualisation deals with perhaps a more balanced approach and the idea discussed in hypothesis two that therapeutic improvisation is a necessary balance between therapeutic and musical influences.

The therapist's musical involvement in therapeutic improvisation can equally affect the therapeutic outcome. The alternating balance between the client and therapist's ability to lead and/or follow in general music therapy terms, can also be applied to the musical components and direction of the improvisation. The therapist should therefore readily acknowledge his/her own musical influences and the potential they have to affect the therapeutic relationship/process.

7.3. Antithetical Expression and the Dialectic of Opposites.

The concept of opposing and alternating aspects of our existence (Jung 1963, 1972), can be applied to various avenues of therapeutic improvisation for people living with the virus HIV and AIDS. In terms of music therapy the condition of opposites may at one level be ascribed to the therapeutic relationship :

“The therapist is involved-yet-detached ; he is “in” the world of his patient, but not “of” it.” (Cox 1978)

and at another level related to the actual representation of the musical material as it presents itself. It is the proposition of this project that opposites constantly change their momentum within the therapeutic improvisation.

Different levels of opposites can be identified further :

- a) the opposites between the musical expertise of the client and therapist.
- b) the opposites between the HIV/AIDS diagnosis and the potential death of the client and the negative diagnosis and well-being of the therapist.
- c) the opposites between the training of the therapist and the non-training of the client.

All of the above are embryonic in terms of the process as a whole and as individual components within the unification of the overall music therapy procedure. The correlation of antithetical expression and death and dying, which lies at the core of these findings and indeed the

project as a whole, would seem to suggest that the varying delineations can be inferred at various musical and therapeutic levels.

The identification of opposing styles of improvisational invention having direct consequences on the therapeutic outcome and thus the music therapy process as a whole is highlighted and discussed by the three clients :

"For me contrast is very important. I want to express two different parts of me, musically. The aggressive angry part of me and the more gentle calmer part. I want to experience how each affects the other. " (Eddie)

"We always have two parts to our improvisations and they are always very different and opposing in content. It seems as if we travel through the first part to get to the second. It's the second part that is always the most important for me." (Charles)

"I have talked about darkness and light often (see 6.3.2.2). I see these two sides of my musical and therapeutic expression as being separate and yet totally integrated as a direct expression of my musical personality within the bounds of our music therapy journey. It could be possible to see one or either as positive or negative, good or bad or beneficial or detrimental. I do not consider opposites in these terms, I see them as differing polarities of my own expression. At times they are completely separate and at other times they seem essentially unified whilst defending their own uniqueness of origin. I hold opposites within my musical expression and I share and integrate them within our relationship. For me they form the crux of our work together." (Francis)

Each client discusses polarities of expression from differing viewpoints : Francis in terms of darkness and light, Eddie in terms of aggression and calm, and Charles as a journey from one state to another. Conjecturally the connection of opposites, in terms of musical outcome and therapeutic consequence, could have a direct relation to the representation of illness and death and dying. Through my own experience as a music therapist I found that all the clients I worked alongside battled with two sides of their persona when coming to terms with living with HIV and AIDS. This was clearly manifested through their improvisational expression and was often specifically discussed if verbally assessing the improvisations.

It would appear conclusive that the incorporation of musical and therapeutic opposites is critical in determining the direction of the therapeutic process.

7.4. Emotional Responses and Objective Data.

By comparing the emotional responses of clinical psychology (Miller, Brown 1988) (see 1.3.1.), alongside the psychotherapeutic themes (Winarski 1991) and main phrases incorporated by the client and external validators during the project (see table 7.4.), it is possible to find similarities and differences in information. Commonalities in terminology can be seen to be self-explanatory in terms of the nature of the virus. Aspects of shock, guilt, anger and the fear of death and dying can be clearly attributed and anticipated for a person living with a life-threatening illness.

note. All of these feelings can be viewed as positive and/or negative emotions within the therapeutic development.

<u>Clinical Psychology</u> (Miller, Brown 1988)	<u>Psychotherapy</u> (Winarski 1991)	<u>Music Therapy</u> (Lee 1992)
Shock. (possibility of death)	Why me ?	Fear of death
Fear and Anxiety. (course of illness)	Denial.	and dying.
Depression. (Health decline)	Shame and Guilt.	Anger.
Anger and frustration. (Inability to overcome	Abandonment.	Violence.
the virus.)	Betrayal.	Frustration.
Guilt. (Misdemeanours and	Loss of control	Instability.
punishment.)	and dependancy.	Inward looking/Extrovert.
Hypochondriasis and	Fear of dying.	Inevitability.
obsessive disorders.	Loss of future.	A need for space and
(Searching for physical	A life of unknowing.	listening.
diagnostic evidence.)	Living fully.	Stuckness.
	Family issues.	Protecting the pain.
	Financial concerns.	Self-protection/
	Envy of health.	self-exploration.
		Searching.
		Destructiveness of others.

Table 7.4.

What appears to be illuminating from this comparative data is the differential between the more evident aspects of living with HIV and AIDS mentioned previously and the more circumventory avenues of searching, listening, protecting and exploration mentioned only in the music therapy extractions.

note. Certain of the afore mentioned phrases identified through the music therapy information can be related to section 7.3. e.g. inward looking/extrovert and self-protection/self-exploration.

It would appear significant that therapeutic improvisation has the ability to raise certain aspects of living with HIV and AIDS that are not identifiable through the studies of Miller, Brown and Winarski.

In terms of the available verbal material made by the client and the three outside validators, it is possible to extract certain areas of congruent information. In general terms the data provided a dual level of information : a) those instances where one or more person expressed a similarity of interpretation, and b) those instances where one or more person expressed a differential of interpretation. With regard to these findings it is suggested that each perspective is of equal importance in balancing information that provides both simplicity and complexity of results. Taking into account the physical variables of each client's stage within the progression of the virus (see 2.5.), it can be seen to be significant that there are similarities in the verbal data for the two analyses of Eddie and Charles. There is the concordant view that a period of uncertainty leads to a subsequent more direct expression. The information with regard to Francis is more complex. The differences in therapeutic context (a solo improvisation) and the health (in the later stages of the virus), provide a dual set of variables that resulted in an uncertainty of communication to the outside

validators. The general conclusion arrived at was that Francis was using his intellectual musical ability to conceal his true feelings.

7.5. Personal Evaluations.

"the important thing to say is this : with you it's been the best – the best years and the most love." (Monette 1988)

My initial attempt at expressing the personal issues faced whilst working alongside people living with the virus HIV and AIDS developed during the later stages of this project (Lee 1991) (see volume two, Endings). It examines my own personal perceptions of endings and the relevance these feelings had upon all stages of my research and therapeutic journey whilst at City University and London Lighthouse.

Feelings of "fear" and "not knowing" are terms that served as both potentially positive and negative in the music therapy setting. The initial "fear" of not being able to clearly evaluate my own feelings, and the "not knowing" how the music therapy process might develop (due to lack of reference points from similar work), on one hand acted as an incentive to progress slowly and honestly. On the other hand it served as a potential hazard for clearly establishing a therapeutic direction necessary for the client's needs.

The hypothesis that the therapist has skills and knowledge from which to aid development and growth, can in itself act as a negative force within the therapeutic process (Bosnak 1989). The balance between knowledge, informed ignorance and fear became central in formulating a therapeutic procedure that was both true to myself as therapist, and which acknowledged a defencelessness that was essential for the therapeutic relationship. At times the concept of

attempting to mould such emotional and stressful dimensions into an academic study, felt futile and irrelevant. The results of the musical analyses on one level were illuminating in terms of the micro-musical content and the therapeutic outcome. On a more feeling level however questions arose in terms of the validity of such an indepth study with the ultimate conclusion each client faced.

Throughout the investigation of music therapy literature it became apparent that there is a need for music therapists to be more honest about their own personal feelings within the therapeutic setting. Does an academic study preclude the emotions of the researcher, and do the feelings of the music therapist detract from the validity of the music therapy itself ? From my own personal experiences and throughout the period of this project I would suggest that the answer is "no." My own inadequacies, dilemmas and sensitivities as a researcher and therapist were integral to the processes and results of this investigation. It was essential that I acknowledged my own vulnerability alongside my knowledge and experience as a musician and therapist. The death of Francis (see 6.1.2.4.) and the possible physical deterioration of Eddie and Charles during the writing up of this project added dimensions of quality and celerity that can be identified at all levels of the research.

I felt and experienced shock, fear, anxiety, depression, anger, frustration and guilt (see 1.3.1.). I do not wish to over emphasise or apologise for their inclusion within this project, but rather to stress the importance of acknowledgement and examination of the therapists's feelings in all areas of music therapy intervention and research.

7.6. Possibilities for Further Research.

Through this study it was hoped to broaden and develop the possible avenues of process orientated research in music therapy. The subsequent results raise more questions than can be adequately answered within the bounds of this project. To extract a more representative method of therapeutic improvisation it would appear appropriate that further studies need to be undertaken looking at a complete series of improvisations with both a) an individual client and b) a whole series of similar or varying clients. The rigour of the analysis also needs to be addressed. In terms of quantitative and qualitative data and interpretation, where lies the most appropriate balance that will allow for significant results ?

One of the main reasons for choosing the client group researched within this project was the opportunity of evaluating clear, articulate feedback about the music therapy process. The assumption that the empirical examination of verbal material for a person living with HIV and AIDS will accord unequivocal information about the music therapy process can only be deemed significant if it is accepted that the client in question is of sound mind and is not biased in any direction. Of course it would be foolish to deny the variables within the above method of execution. What we are left with at this stage then, is the acknowledgement of the problems and impracticalities balanced against the discovery and possible illumination of enquiry into the processes of music therapy.

Why there is only a small amount of research being undertaken with non-impaired and verbally comprehensible clients within this country (Hoskyns 1988, Rogers 1991), can be inferred at several levels :

a) that the base of information with regard to therapeutic/clinical procedure and practice is small.

b) that the amount of previous research from which to base new studies is small.

c) that it is more difficult to accommodate the intricate data of a verbally articulate client within the bounds of a strict quantitative study.

These problems aside it is the author's view that if we are to discover more about the dynamics of music therapy, then further research needs to be undertaken with verbally articulate clients.

Another question that needs to be addressed when researching music therapy is : "who is the research for ?" It is my own personal view that if the client's needs are not focussed somewhere within this question, then the ultimate findings and results could appear to be invalid. Music therapy at its most fundamental level deals with the relationship between therapist and client through music. Is it not possible to redress the balance of outcome research with the concepts of collaborative enquiry, doing research with rather than on people (Reason 1989) ? The terms researcher and co-researcher would seem to be a more balanced and conducive approach to researching music therapy than those of researcher and subject.

7.7. Conclusion.

The journey travelled throughout the three years of this project was influential in changing my concepts of music, music therapy, and

death and dying. It was often difficult to detach the personal issues of a client's illness and subsequent death from the intellectual rigour demanded by such a research project. It often also seemed incongruous to try and formulate various research methodologies when working with issues of death and dying. That Francis was unable to see the fruition of his beliefs in music therapy bears testament to the client's, therapist's, and researcher's work within this area. To attempt any personal descriptions of my own sense of loss as a therapist, without resorting to sentimentality, was constantly complex and painful.

These difficulties aside, the project enabled me to research music therapy in terms of both music and therapy with equal weight. My belief that, behind the exterior aural layers of therapeutic improvisation, lies a wealth of musical and therapeutic treasures to be harvested and explored, will hopefully begin to gain wider circulation as a result of this project.

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